director

the funeral

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filled etely pup physician aftending á

PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY Carroll MARYLAND Marvland c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If autside corporate limits, write c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) SVKe SVIIIe 22yrs.lmo.10days Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital 1009 W. 38th St. 4. DATE OF DEATH NAME OF Middle Charles Edward Anderson (Type or print) August 5 SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years last birthday) Male White July 3, 1901 WIDOWED | DIVORCED IX 10a. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) during most of working life, even if retired) Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Harry Anderson Addie Sakers 17. INFORMANT IS, WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO Address Bo Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease **DUE TO** Parkinsonism Conditions if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY Psychosis with post-encephalitis. 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year 20d. INJURY OCCURRED factory, street, affice bldg., etc. Hour a.m. While Not while at work at wark 21. I certify that (1) (this hospital) attended the deceased fram March 7, ...... 1955 ... to August 22..., 1960. that (1) (we) last saw the deceased alive an August 22, 1960, and that death accurred at 11:45 Pom the causes and on the date stated above 220 SIGNATURE ATTENDING PHYS. DIRECTOR | PHYS. 22c. PHYSIC AN'S 22d. ADDRESS NAME (Type) Agustin delCampo. Springfield Hospital, Sykesville, Md. 23g, BURIAL CREMATION. 25b. REGISTRÁR'S SIGNATURE

08955

Balto City

IF UNDER 1 YEAR IF UNDER 24 HRS

Heurs

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

INTERVAL BETWEEN ONSET AND DEATH

PERFORMED?

YES NO IL

(State)

SIGNED 60

Years

Years

(County)

DAUG 3 1 '60

Days

Months

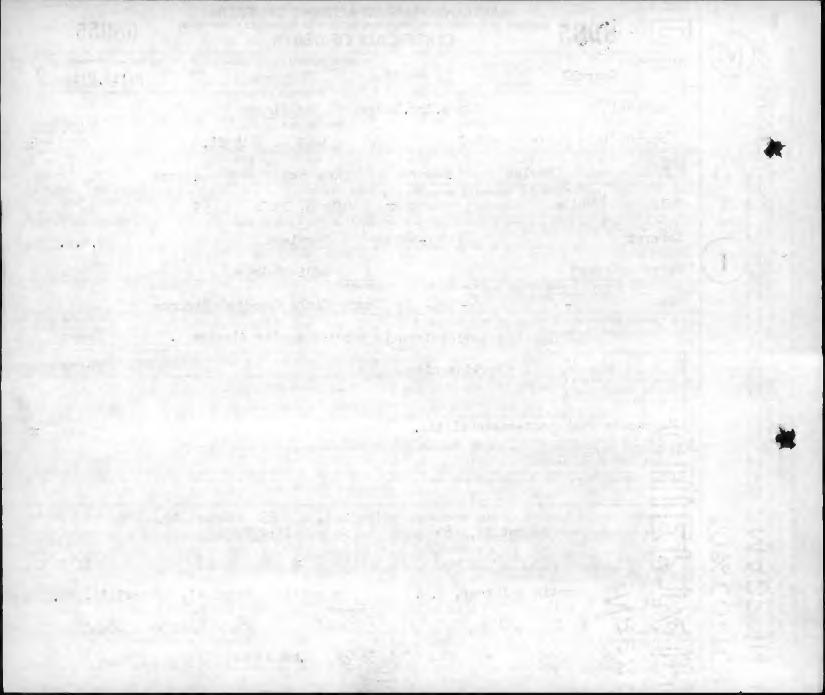
IS RESIDENCE

YES NO 1

Year

1960

FUNERAL DIRECTOR:



John A. Monan 3000 E. Baltimore St.

00050

85	186	1+ 20.	CERTIFICA	AJE	OF DEATH	1		(1)	0000	
o. COUNTY	Carroll	-LvC	MARYLAND	0	SUAL RESIDENCE (W. STATE Mary L	-	d lived. If instituti b. COUNTY		before odmi	. V
RURAL and give	(If outside corporate limit necrest town) SVILLE	s, write c	LENGTH OF STAY IN 16		city or town (if Baltimore		rote limits, write R	URAL and giv	re nearest tov	vn)
d. NAME OF HOSP OR INSTITUTION	ITAL (If not in hospital, gi		dress)		37 N. Cha	rles S	t., Balto	0, 18,	e. IS RE ON YES [	A FARM?
NAME OF DECEASED (Type or print)	Fin Kathe		Middle Butler		Blanck	4. DATE OF DEATH	Mor Augu	ust 24	Doy 1960	Yeor 1960
. sex Female	1		NEVER MARRIED		12-897		9. AGE (In years lost birthday)	IF UNDER 1	YEAR IF UND	DER 24 HF
during most of wo Housew	rking life, even if retired)		ND OF BUSINESS OR IND	DUSTRY	11. BIRTHPLACE (SIGN		ountry)		S.A.	COUNTR
3. FATHER'S NAME  James B	utler			14.	MOTHER'S MAIDEN		stasia	Conco	ran	
	ER IN U. S. ARMED FOR			nform	field Hos	pital 1	Records,		ville,	Md.
Conditions, if gove rise to couse (o), stating lying couse lost	immediate DUE TO								10 da Hyper years	-
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED?  PERFORMED?  YES \( \sigma \) NO (A)										
20a. ACCIDENT WAS UNDERLYING  20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Parl II of item 1B.)  20c. TIME OF INJURY Month, Doy, Year  Hour a. m.  19 of work  19 of work										
21. I certify that (I) (this haspital) attended the deceased from June 1, 10 60 to August 24, 19 60, that (I) (we) last saw the deceased alive an August 24, 19 60, and that death accurred at M, from the causes and an the date stated above.										
220. SIGNATURE 22c. PHYSICIAN'S NAME (Type)	vitin d	el C	mpo		PHYS E	MED. DIRECTOR	STAFF PHYS.		gust 2	SIGN
V	Agustin de		OO, M.D.		Springfiel MATORY		e Hospita			le, l
Burial  FUNERAL DIRECTO	Aug 27, 1	960	New Catheda	al (		Bald		Manu La ISTRAR'S SIGN	NATURE	
John A M	2000	& R	1+:mann 5+		DATE A	UG 29'6	SU G	Clur & :	Trava	

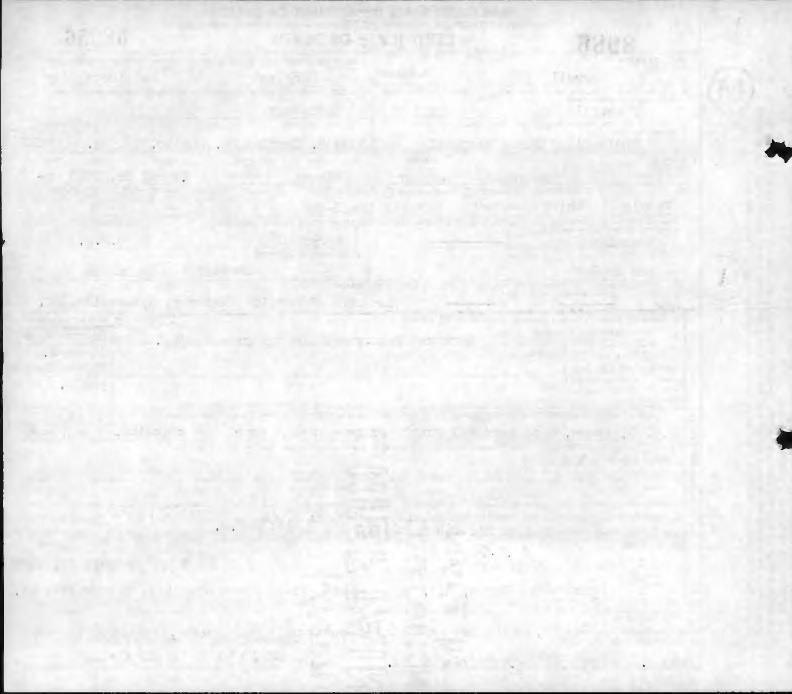
the funeral director, be filed with Then piecse remave carbon papers. Pages I and 2 should may be revained by the haspital ar attendit. It yician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and campletely filled page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages I of the State Board of Health prior to burial, cremation, or remavol, and in any event, within 72 haurs after death.

rs offer dooth. Page 4

law requires that the death certificate be executed within 24:

TO HOSPITAL OR ATTENDING PHYSICIAN: VR A15 (4) 15M 9/59



DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08957

8	3981 DIVISIO	CERTIFIC	ATE OF D		ARYLAND	08957
1. PLACE OF DEATH	arroll	MARYLAN	CT 4 TO	DENCE (Where deceased laryland	b. COUNTY Ca	ridence before admission)
b. CITY OR TOWN (I RURAL ond give no Taney to		, write c. LENGTH OF STAY IN 15 years		OWN (If outside corpord	ote limits, write RURAL	and give nearest town)
d. NAME OF HOSPIT OR INSTITUTION	AL (If not in hospital, givest Baltin		d. STREET A	DDRESS Baltimore S	t. (Ext.)	IS RESIDENCE ON A FARM? YES \[ \] NO \[ \overline{\text{X}} \]
3. NAME OF DECEASED (Type or print)	John	Middle Donalđ	Los Boor	OF	August	9 1960
s. sex Male	9923 2 1	7. MARRIED X NEVER MARRIED [ WIDOWED DIVORCED [	med	r 20, 1906	AGE (In years lest bid hop)  yrs.	NDER I YEAR IF UNDER 24 HRS 11ths Days Hours Min.
10a. USUAL OCCUPATION during most of worl Route Sa.	ON (Give kind of work de king life, even if retired) LESMAN	Bakery		ACE (State or foreign couryland	intry)	U.S.A.
13. FATHER'S NAME	John W. Bo	oone	14. MOTHER'S	MAIDEN NAME Cai	rdė Wolfe	}
15. WAS DECEASED EVE (Yes. no. or unknown) No	R IN U. S. ARMED FORC (If yes, give wor or dates of ser		Mrs. J. D	onald Boone	Address Taneyt	cown, Md.
Conditions, if a gove rise to i couse (a), storing lying cause lost.	the under DUE TO	Hypertens	iois and		Sclenos	
200. ACCIDENT W		20b. DESCRIBE HOW INJURY OCCU				PERFORMED? YES NO
20c. TIME OF INJUR		20d. INJURY OCCURRED While Not while of work	s. PLACE OF INJURY ( foctory, street, affice	Home, farm, a bldg., efc.)	or fown)	(Caunty) (State
saw the decea		attended the deceased from	om 2/16/S	59.12 to	8/9 the causes and a	1960 that (I) (we) last the date stated above
22c, PHYSICIAN'S	2.1.7	neaugh	M.D. ATTENDIN PHYS.		STAFF PHYS.	8/10/60 8/10/60
NAME (Type)	K, S, A	nc Vaugh		aneyt	-oven	Mcl. (State)
230. BURIAL, CREMATIC REMOVAL (Specify) Burial 24: Purchal DIRECTOR	Aug. 12,	33.0				roll, Maryland
Werwyn Z.	Fuss - fu	Taneytown, Md.		DATE AUG 15 '6		1 S. Kraus

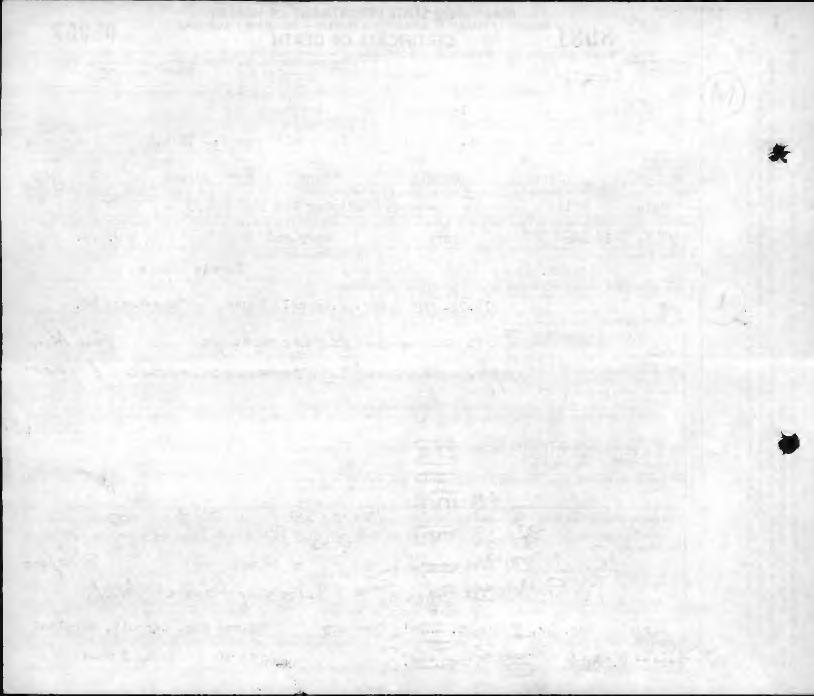
the ottending physician and campletely filled they the funeral director.

Then please remaye carban papers. Pages 1 and 2 should be filed with moy be retained by the hospital ar ottendry. Assiction.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and campletely filled page 3 should be detached for use as the burial-transit permit. Then please remaye carban papers. Pages 1 of the State Board of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death. VR A15 (4) 15M 9/59

low requires that the degith certificate by exampted within 24 hayrs after death. Page 2

TO HOSPITAL OR ATTENDING PHYSICIAN:



DVI AND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) 1. PLACE OF DEATH e. COUNTY b. COUNTY ral director, Page I for your files. of Health, Maryland Carroll Carroll MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits, e. LENGTH OF STAY IN 15 For your Board of F write RURAL and give neerest lown) Union Bridge Westminster d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO X State Year NAME OF Month Day 2, and 3 to the H DECEASED in e DEATH (Type or print) GEORGE BOSTIAN 30 1960 K. August 6. COLOR OR RACE 7. MARRIED NEVER MARRIED T 9. AGE (In years | IF UNDER 1 YEAR ! IF UNDER 24 HRS. S. SEX 8. DATE OF BIRTH may lest birthday) Months Min. Male WIDOWED DIVORCED S 12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY done during most of working life, even if retired) 8. Give Pages sabed 13. FATHER'S NAME form PM3. ARMED FORCES? (Yes, power unkown) ( INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Arteriosclerotic coronary disease with old infarct in pencil more of left anterior ventricle s Office burial-Conditions, if any, which' (6) gave rise to immediate cause "pending" DUE TO (a), stating the underlying the word "pending Medical Examiner" pesn PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOPSY CERTIFICATION PERFORMED? 2 YES TA NO should 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury In Part I or Part II of item 18.) 20s. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. DEPUTY MEDICAL EXAMINER: execute the certificate, writing ald be forwarded to the Chief / VERAL DIRECTOR: Page 3 s 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (State) 20c. TIME OF INJURY Month, Day, Year (County) factory, streat, office bldg., atc.) While Not While at work el work 21. I certify that I took charge of the remains described above, held an Autopsy K. Inspection Inquiry and in my opinion Natural causes Accident Suicide Homicide Undetermined manner death resulted from: CHIEF MEDICAL EXAMINER ACTUAL DATE SIGNED ASSISTANT MEDICAL EXAMINER should be for FUNERAL 1 SIGNATURE DEPUTY MEDICAL EXAMINER 8/31/60 EXAMINER'S Russell S. Fisher, M.D. NAME (Type) Address (Street, city, town, or county) 228. BURIAL, CREMATION, 226. DATE THEREOF NAME OF CEMETERY OR CREMATORY 22d, LCCATION (City, town, or country (State) 400 O 24a. REC'D BY REGISTRAR I WINER AL DIRECTOR Outland S. Kraus **V5, A15ME.** 5M 7/59 DATE

MINES TO STANKING LEWINGE MORES The second secon With the Land - to The Late of the Control of the Contr law requires that the death certificate be executed within 24 havrs after death. Page 4 ord 2 shauld be filed with may be revained by the haspital ar attending hysician.

TO FUNERAL DIRECTOR: After this certificate as been signed by the attending physician and campletely filled page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 the State Baard of Health prior to burial, cremation, ar removal, and in any prefit. Within 72 hours offer death. TO HOSPITAL OR ATTENDING PHYSICIAN:

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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	CE	RTIFIC	ATE	OF	DE	ATH

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1. PLACE OF DEATH a. COUNTY Ca	arroll	MARYLAND	2. USUAL RESID	Maryland	ased lived. If institut b, COUNTY		
RURAL ond give nee Sykesvill	Le	c. LENGTH OF STAY IN 16 byrs.9mos.20day		OWN (If outside co	rporate limits, write J	RURAL and give	neorest town)
OR INSTITUTION	AL (If not in hospitol, give street eld State Hospi		d. STREET A		ngton St.		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	Franklin	Middle Carl	Cummi	OF	_		Day Year 26, 1960
s. sex Male	6. COLOR OR RACE 7. MAR WIDOW	THE PARTITION IN	Octobe:		9. AGE (In years last birthday) 9 30 yrs	Months Da	EAR IF UNDER 24 HR ys Haurs Min.
100. USUAL OCCUPATIO during most of worki Stock cles 13. FATHER'S NAME	ing life, even if retired)	KIND OF BUSINESS OR INDUST	Mar	ACE (State or foreig Yland MAIDEN NAME	n country)	1	OF WHAT COUNTRY
Vincent Cu	mmings		Barb	ara Kress			
15. WAS DECEASED EVER	IN U. S. ARMED FORCES? 16.	10 21 EPOC	ormant pringfi	eld Hospi	Add tal Record	dress ls	
Conditions, if or gove rise to in couse (a), slating the lying couse last.  Schizophi	DUE TO  (b)  numediate the under  (c)  ER SIGNIFICANT CONDITIONS  CONDITIONS	contributing to DEATH BUT to	NOT RELATED TO 11fferen	THETERMINAL DIST	EASE CONDITION GI	VEN IN PART 1(	Months:
20c. TIME OF INJURY 20c. TIME OF INJURY 40 Haur a.m.	CAUSE OF DEATH MEDICAL EXAMINER)  Y Manth, Day, Year 20d. 1			Home, farm, 20f. (		(Cau	nty) (State
21. I certify that	t (I) (this haspital) attended alive an August	ded the deceased from N 25,19 60, and that de	ATTENDING PHYS.  22d. ADDRE	a3:05AMrc  MED.  MED.  SS	m the causes a	nd an the d	ate stated above 22b. DATE 8/26/60
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	N. 235. DATE THEREOF 8-30-60	23c NAME OF CEMETERY OR Baltimore Cem		100	CATION (City, fown, altimore		(State)
Wm. Cook, In	signature c., 1217 St.Pa	aul Street		25a. REC'D BY REC DATEALIG 3 0		ISTRAR'S SIGN.	

VR A15 (4) 15M 9/59

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. COUNTY Jose COUNTY MARYLAND b. CITY OR TOWN III subule cornerals C. LENGTH OF STAY IN 16 c. City OR TOWN (if outside corparate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO T NAME OF Middle DATE First Month Day Year DECEASED BOSTICK DEATH (Type or print) 1960/ 9. AGE (In years) 5 SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS. Months I Days WIDOWED | DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? TELEG-RAPHE 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? Address (If yes, give war or dates of service) 18 CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c) INTERVAL BETWEEN Thrombosis PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise to immediate cause DUE TO (a), stoting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY 00 PERFORMED? YES 🔲 NO I CERTIFICA 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of Item 18.) Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc.) White Not while a. m. of work at work D. M. 21, 1 certify that I took charge of the remains described above, held on Autopsy ... Inspection Inquiry . and find that cuta the certificate, writ forwarded to the Chief O FUNERAL DIRECTOR: death resulted from: Natural causes [4]. Suicide . Homicide ... Undetermined couse ... DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER EXAMINER'S DEPUTY MEDICAL EXAMINER TO NAME (Type) 220. BURIAL, CREMATION, 225, DATE THEREOF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (Stote) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS. A15ME(5) DATE 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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	8990	DIVISION OF			ID RECORDS - BALTIMI	ORE 1, A	MARYLAND		089	361	
	CATTO I		MARY	LAND	2. USUAL RESIDENCE (When of STATE Maryland	d .	P COUNTY	Balti	more	_Cit	у
	RURAL ond give nearest lown)  Sykesville  A NAME OF HOSPITAL (If not in OR INSTITUTION  Springfiel	hospita , give street	1 vr. 19	lays	Baltimore d STREET ADDRESS 723 Benning	12	-5 \V	F.	- 4	S RES	IDENCE FARM?
5 5	NAME OF DECEASED Type or print)	First  Margare OR RACE 7 MAR	t Finn	ED [] 8	du Bois  DATE OF BIRTH	OF DEATH	Moni Au	th gust IF UNDER	Day 3 , 1 YEAR		Year 1960 ER 24 HRS Min.
10a	USUAL OCCUPATION (Give kind during most of working life, ever HOLISEWITE FATHER'S NAME  Michae WAS DECEASED EVER IN U. S. A.	Trinn RMED FORCES7 or dates of service)	SOCIAL SECURITY NO.	DR INDUST		ME	AbdA		S.A		Md.
	PART I, DEATH (Enter of PART I, DEATH WAS CA MANEDIATE	USED BY Br CAUSE (a) Br	on chopneum  fected decr	onia	s ulcers				2 ONSE	eeks	DEATH
FICATION	gave rise to immediate couse (a), stating the under ying couse lost.  PART II OTHER SIGNIFIC	DUE TO ME	testatic c pine secon CONTRIBUTING TO DE	arcin dary		of th		•	U	nkno , WAS PERFO	own
MEDICAL CERT FICA	Depressi 200 ACCIDENT WAS UNDERLY OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL EX 20c T ME OF INJURY Manth, Hour o.m.	Doy, Year 20d.	NJURY OCCURRED	20e. PLA	(Enter nature of injury in Pa CE OF INJURY (Home, farm, ory, street, affice bldg., etc.)	20f (City		(	County)	123	(Stote)
ME	рт		rk at work		- 2 /	ĖO	A		0		

21 I certify that (I) (this hospital) attended the deceased from July 14 ... 19 59 to August 31, 1960, that (I) (we) lost saw the deceased alive on August 3. 1960, and that death occurred a 8:05M, Federathe causes and on the date stated above. saw the deceased alive on August 3

MAME/(Type)

Agustin del Campo.

22d ADDRESS Springfield Hospital, Sykesville, Md.

MED DIRECTOR

23a SURIAL CREMATION, 23b DATE THEREOF BUTTLE! (Specify) 8/8/60 8/8/60

23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk. Cemetery

23d LOCATION (City, town, or county)

Baltimore, Maryland

25a. REC'D BY REGISTRAR DATEAUG 8

25b. REGISTRAR'S SIGNATURE

Called & France

aw requires that the death cert ficate be executed within 24 hours ofter death. Page 4

FUNERAL DIRECTOR: After this certificate —s been signed by the attending physicion and campletely filled page 3 should be detached for use as the Illural-transit permit. Then please remove carbon papers. Pages 1 the State Board of Health prior to buriol, cremation, or removal, and in any eyent which 72 haurs after death.

the funeral director, 2 shauld be filed with

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may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate TO HOSPITAL OR ATTENDING PHYSICIAN



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



08363 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland Baltimore c. CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) Baltimore 19 e. IS RESIDENCE ON A FARM? 1318 Forrest Road YES NO IN DATE Manth Year Day 1960 August DEATH IF JINDER LYEAR F JINDER 24 HRS. 9 AGE (In years last buthday) Months. Dovs Hours September 9,1872 12 CITIZEN OF WHAT COUNTRY? U.S.A. Kentucky 14. MOTHER'S MAIDEN NAME Address Springfield Hospital Records INTERVAL BETWEEN ONSET AND DEATH Years Days PERFORMED? YES INO 20e. PLACE OF INJURY (Home, form, 20f (City or lown) (Stote) (County) 1960 to August 4.

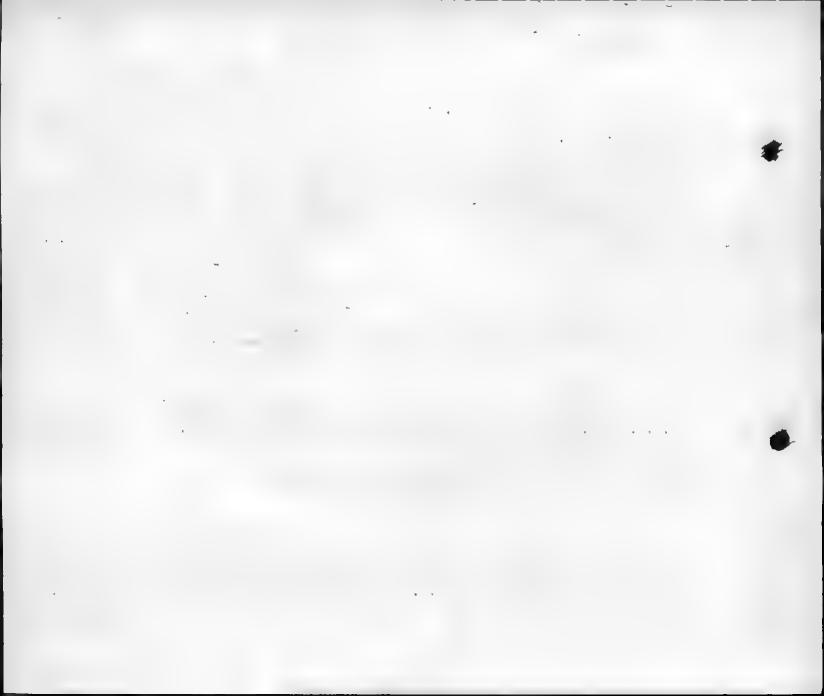
. 19 60, and that death accurred 20:05 Alfram the causes and an the date stated above 225 DATE STAFF PHYS

> Springfield Hospital, Sykesville, Md. 23d LOCATION (City, town or county)

BUPIAL 8 6-60	MEadow!	idge /	3alfa m
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	250. REC'D BY REGISTRA	256 REGISTRAR S SIGNATURE
adin O Connelly.	Essex 21	DATE OF 160	Onther & Krona

MARYLAND STATE DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs ofter death. Page 4 may be retained by the hospital or attending.

TO FUNERAL DIRECTOR: After this certificate been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the buriot-transit permit. Then please remaye caubon papers. ■ames 1 to 2 should be find with the registrar prior to buriot, cremotion, or removal, and in any event within 72 hours after yearh.

VS M15 (4) 15M 9/SS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8982

## **CERTIFICATE OF DEATH**

	(1)	S.S.	R	6
Reg.	Dist.	No.	U	U

	1. PLA	CE OF DEATH COUNTY And		2. USUAL RESIDENCE (When	e deceased lived. If institution, Residence	ce before admission)
	0. 0	100NIT ( 35 NI	MARYLAND	o. STATE	County (1/1)	1 11
		ITY OR TOWN (If outside corporate limits, write	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If our	see corporate limits, write RURAL and g	rive nearest fown)
	K	URAL and give nearest town)	75 1.62	37 1 0075	and To	
7	d. N	NAME OF HOSPITAL (If nat in hospital, give street	oddress)	d STREET ADDRESS	FFFFAEL	IS RESIDENCE
	0	OR INSTITUTION /40 / 22.	.6	1491	72. (7	ON A FARM?
	3 NA	10 6	67	1 / 2 /2	Alstered of	
	DEC	ME OF FIRST CLADITO	Middle	E c / Lost	OF Month	Oay Year
		or print) Esta (7777/(2t)	KYLT	1641/	DEATH Classer	1 4 19 (55)
	S. SEX	6. COLOR OR RACE 7. MARR	IED NEVER MARRIED	8 DATE OF BIRTH	AGE (In years AFUNDER lost birthday) Manths	Doys Hours Min
	_//	Me how		7637,20,3	1 87 yr.	
	10a U! d⊍	SUAL OCCUPATION (Give kind of work done 10b.	KIND OF BUSINESS OR INC	USTRY 11. BIRTHPLACE State or	foreign country) 12. CITI	IZEN OF WHAT COUNTRY?
		interpre Dailes	ameral 1	water White	store Caratell LL	S.a.
	13. FAT	HER'S NAME	1	14. MOTHER'S MAIDEN NA	ME	(
		22 Reply Jorita		77:12m	Monthall.	
	15 WA	S DECEASEDEVER IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO 17	INFORMANT	Address 144	4 1122 V
			12	rache K. Je	- 5 Miles to 2 the	2 Tromas
	19.	CAUSE OF DEATH [Enter only one cause per lin	ne for (a), (b), and (c).]		11111111111	INTERVAL BETWEEN
		PANTI DEATH WAS CAUSED BY:	Caron MA	utter so	· Land	ONSET AND DEATH
		DUE TO		/		7
	ء ا ا	anditions if any which )	King is	here one.	el:	seneral
	9	ove rise to immediate	acour.	01 (40	CALLES OF	4-1-4
		ring cause last.	Aloua S	CAPARAN	+English to	
	_  -≐	PART II. OTHER SIGNIFICANT CONDITIONS	ONTRIBUTING TO DEATH B	IT NOT RELATED TO THE TERMINA	AL DISEASE CONDITION GIVEN IN PART	TION 10 WAS ALTOPSY
	CATION				THE TOTAL LONGING CONTRACTOR OF THE PARTY OF	PERFORMED?
		ACCIDENT WAS UNDERLYING TO 20b. DESC	CRIBE HOW INJURY OCCUR	IED (Enter noture of injury in Pol	the Port II of Jam 18 )	YES NO
	SERVIE OF OF	ACCIDENT WAS UNDERLYING (20b. DESC CONTRIBUTING (20b. DEATH EITHER, NOTIFY MEDICAL EXAMINER)	- Magni Occon	ten ferrior notate of diffast to to		
			UURY OCCURRED 20e	LACE OF INJURY (Home, farm,	205 (0)	
	WEDICAL 200	Hour o.m. While	Nat while	actory, street, office bldg., etc.)	ZOT. (City or fown) (C	county) (State)
	₹	p. m, IF of work	of work			
	21	. I certify that I attended the decease	*	7-7 1960, 10 Cu		ast saw the deceased
	al	ive on bull 195	20 and Wat dea	h occurred at 1.55	from the couses and an th	e date stated above.
		1/3/0/	X0 . 1 6	TOUR SE	ORESS (Street, city or town, state)	DATE SIGNED
	SIC	THATURE UT LUCIO CO	THERE IT	Mr. West	weland In 10	10 8/3/60
	PH	YSICIAN'S				
	N/	AME (Type)				/ /
	220. BL	JRIAL, CREMATION, 226 DATE THEREOF	22c. NAME OF CEMETERY	OR CREMATORY 2	2d. LOCATION (City, town, or county)	(State)
	J. J.	100 S. 1960	1 horisting	1/2022/14	Reserved box to	total mil
	23 FUN	NERAL DIRECTOR'S SIGNATURE	ADDRESS	246. REC'D	BY REGISTRAR 246. REGISTRAR'S SIG	NATURE
	, X	2 little profit	Thortte.	PATE AL	JG 8 '60 C. Than	& Kroset
1			7	7		



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18	
	MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1000000000000000000000000000000000000	
FOR STATE	Reg. Dist. No.	
HEALTH DEPT.	PLACE OF DEATH  2. USUAL RESIDENCE (Where deceased I'ved. If institut on Residence before odm as on,	
26 E ( N A)	c. COUNTY Carroll MARYLAND O. STATE Maryland b. COUNTY Montgomery	. 2
9522 ( M)	b. CITY OR TOWN II outs de corporate mate winte RURAL ond give negrets fown)	
8:5E	and give hearest fown)	
essac your	Sykesville lyr. 6mos. 9days Silver Spring  A NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  A STREET ADDRESS  A STREET ADDRESS  A STREET ADDRESS	
April 6	ON A FARM	
# P	Springfield State Hospital 12813 Matey Rd.	· 🖳
8 - 2 6	3. NAME OF First Middle Last 4. DATE Menth Day Year OF	
de la comp	(Type or print) Mary Eloise Tonner Garvey DEATH August 8. 1960	
die die	5. SEX 6. COLOR OR RACE 7 MARRIED TO NEVER MARRIED TO B DATE OF BIRTH P AGE (10 years ) IF UNDER TYEAR IF UNDER 24 H	HFF
T S T S T S T S T S T S T S T S T S T S	Female White WIDOWED DIVORCED July 26, 1918 1918 1918 Days Hours Min	
4 5 0 C &	100 USDAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUN	JTRY
72, dec	during most of working life, even if refired)	
2-4-1	Housewife	
M.J. William	13. FATHER'S NAME	
P C tu	Michael Tonnar Clara Phister	
A STATE OF THE STA	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address  [Yes, no., or unlinewed] 1 (If yes, one was or delete of section)	
E # . B	No - Springfield Hospital Records	
<b>美型高电影</b>	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b) and (c) ]	
455 CK	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  Interstitial pneumonia  Day	
T S S S S S S S S S S S S S S S S S S S	F. 3 & 3.	
Fig. 25	JA DUE TO	
2 0 to 5	Conditions, if any, which (b) gave rise to immediate course	
Project	(e), storing the underlying) DUE TO	
100 min	(c) (c)	
In a second	PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOP	
TO SE	Schizophrenic reaction, catatonic type.	
2.00	200. EXTERNAL CAUSE WAS 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18.)	
Me Not	200. EXTERNAL CAUSE WAS PRIMARY Dec CONTRIBUTING CONTRIBU	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		the l
# 45° 0	Hour o, m. White Not white factory, street, office bldg., etc.)	
ing of		
A DOG	21. I certify that I took charge of the remains described above, held an Autopsy 🔼, Inspection 💽, Inquiry 🔼, and in	my
1 7 0 0 E	opinion death resulted fram: Natural causes K., Accident, Suicide, Homicide, Undetermined monner	
Sold Sold Sold Sold Sold Sold Sold Sold	4 51	
Marie Sample	ACTUAL SIGNATURE DATE SIGNED	)
N S S S S	ASSISTANT MEDICAL EXAMINER [7]	
The the	EXAMINER'S / James T Manch M D	
E S SE D	THAME (TYPE)	
10分割	ACTION ALL CONTRACTOR AND ALL CO	
E 0 4 6 0	Barial ang. 11, 1960 aplington Mall-Cem, arlington Va	
VS ATSME	23. FUNEFAL DECTOR'S SIGNATURE  ADDRESS Wash, OC 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE	
&M 2/57	H. Wen, WE Vol 2224-Wis. Che, n. W DATE AUG 15'60   Chillen S. thous	
		-



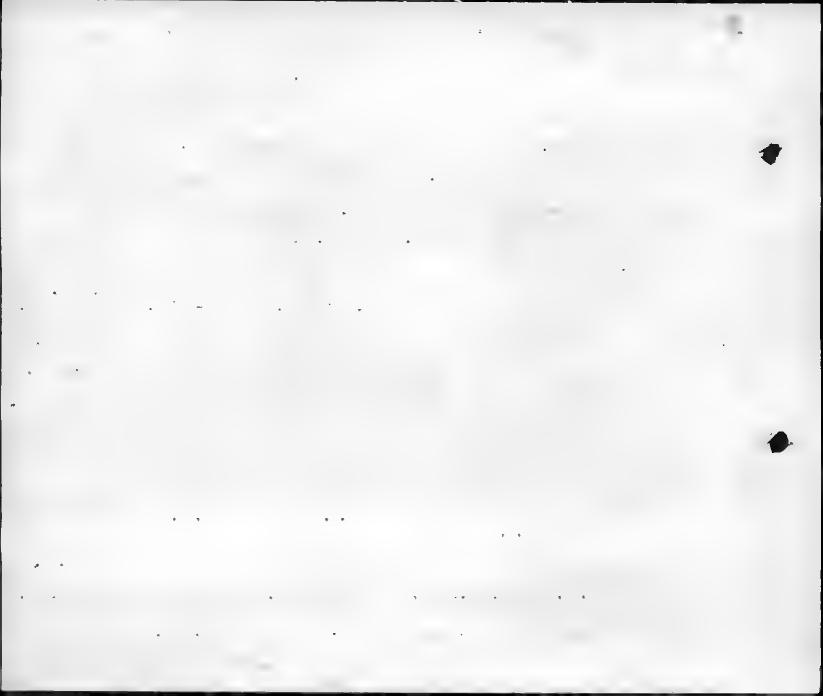
VR A1S (4) 15M 9/59

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MARYLAND	STATE	DEPARTMEN	IT.	OF	HEA	LTH	1
LOP STATISTICAL	DECEMBEL	AND DECODE	D 4	27154	ODE 1	84.4	d

8996 CERTIFICATE OF DEATH

8996	CERTIFICA	TE OF DEATH	\	08968
1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2 USUAL RESIDENCE (WHO a. STATE Md.	ere deceased lived If institution R b COUNTY	tesidence before odmission)  Carroll
b CITY OR TOWN (If outside corporate limits, w RURAL and give nearest town) Sykesville rural	rife   c LENGTH OF STAY IN 16		outside corporote limits, write RJRA. .le – rural	, and give nearest town)
d NAME OF HOSPITAL (If not in hospital, give : OR INSTITUTION  Oakland Mill Pd.	street address)	d STREET ADDRESS Oakle	und Mill Rd.	e is residence on a farm? yes \( \) no \( \)
3. NAME OF First DECEASED (Type or print) EDWARD	Middle $R_{ullet}$	GI SBURNE	4. DATE Month OF DEATH AUGUST	Day Year 28 1960
	MARRIED NEVER MARRIED DOWED DIVORCED	B DATE OF BIRTH	lost birthday) Mo	onths Days Hours Min.
100 USJAL OCCUPATION (Give kind of wark done during mast of working life, even if retired) Retired Owner	Trucking Co.		ar foreign country)	12 CIT ZEN OF WHAT COUNTRY?
13. FATHER S NAME  John Gisburne		14. MOTHER'S MAIDEN I	NAME	
IS WAS DECEASEDEVER IN U. S. ARMED FORCES' (Yes no or unknown) (If yes, give wor or dotes of service)  TO	9)	Mr. Edward H.	Gisburne-380 S.	hurst, Ill. Kenilworth_Ave.
Canditions if any which gave rise to immediate cause (a), stating the under-lying cause last (c)  Part II OTHER SIGNIFICANT CONDITI	ARTERIOSCLEROTI  HYPERTENSIVE CA ONS CONTRIBUTING TO DEATH BU	C HEART DISEAR	DISEASE	20 min.  15-20 yrs.  40 plus yr:  N PART 1(0) 19, WAS AJTOPSV PERFORMED? YES \( \text{NO } NO
PANT II OTHER SIGNIFICANT CONDITI	DESCRIBE HOW INJURY OCCURR	ED (Enter noture of injury in	Part I or Part II of stem 18)	
Hour o. m.	20d INJURY OCCURRED While Not while of work of work	PLACE OF INJURY (Home, form octary, street, office bldg., etc.	20f (City ar town)	(Caunty) (State)
21 I certify that (I) (this haspital) a saw the deceased a ve on s			ta 8,28,60 ,	on the date stated above
22c PHYS CANTE NAME (Type)	1	M.D ATTENDING MD 22d. ADDRESS	ED STAFF	8.20.00
230 BURIAL, CREMATION, 236 DATE THEREOF	on, Jr., 11.D.		ar Eldersburg	
Cremation 8/31/60	Green Mount	Crem.	Balto Md. D BY REGISTRAR ZSB REG STRA	AR'S SIGNATURE
Min. J. Sickne	t Sour De	ALA N	16 3 0 160 Call	7 & HADIN



offer death. Page 44

8997 PLACE OF DEATH o. COUNTY

CERTIFICATE OF DEATH

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE 6 CO.INTY Balto.City b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURA, and a ve nearest town] 27yrs.6mos.10 Sykesville Baltimore d. NAME Of HOSPITAL (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO IX Springfield State Hospital Cambria St. NAME OF Middle Yeor DECEASED Graf August Henry 30. DEATH 19 (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 8 DATE OF BIRTH 9 AGE (In years S SEX dat birthdoy) Months Days White Dec. 11.1868 Male 12 CITIZEN OF WHAT COUNTRY? 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or fore gn country) during most of working life, even if retired) U.S.A. Maryland 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME Charlotte Henry L. Graf IS, WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO 17 INFORMANT Address Yes Stant her. Springfield Hospital Records INTERVAL BETWEEN 18 CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c) } ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Arteriosclerotic heart disease Years IMMEDIATE CAUSE (a) **DUE TO** Acute pancreatic duct abscess Weeks Condit ans if ony, which gave rise to immediate **DUE TO** couse (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G VEN IN PART 1(0) 19 WAS AUTOPSY .S. assoc. with circ. dist. with gebral arterios clerosis with YES TO NO psychotic reaction. 20a ACCIDENT WAS UNDERLYING I 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B) OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PEACE OF INJURY (Home, form, , 20f (City or town) 20c. TIME OF INJURY 28d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) While Not while at work of work 21 I certify that (I) (this haspital) attended the deceased fram March 7, 1955, ta August 30, 1960, that (I) (we) last saw the deceased glive an August 29, 19 60, and that death accurred at 6: 10AMbm the causes and on the date stated above 22a SIGNATURE ATTENDING M.D. 22c PHYSICIAN S 22d ADDRESS NAME (Type Agustin delCampo, M/D. Springfield State Hospital, Sykesville, Md. 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION (State)

250 REC'D BY REG STRAR

puo 60 8 remove a physici ā ò permit gned 660 oy be retained by the hos FUNERAL DIRECTOR: Afri 0

VR A15 (4) 1SM 9/\$9



VR A1S (4) 15M 9/59

	MARYLAND STATE DEPARTMENT OF HEALTH
MA	BIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLANI
99	CERTIFICATE OF DEATH

08970

I. PLACE OF DEATH O. COUNTY MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence of STATE b. COUNTY blank	
Garrott	Maryland Mont  c. CITY OR TOWN (If outside corporate limits, write RURAL and c	gomery /
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)  Sykesville  4 mos. 3 days	Silver Spring	3 0 -
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
Springfield State Hospital	2021 Osborn Drive	YES NO T
3 NAME OF First Middle DECEASED	Lost 4. DATE Month	Day Year
(Type or print) Harriet Beulah	Grier DEATH August	4, 160
S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED	8 DATE OF BIRTH 9 AGE (In years IF UNDER lost birthdoy) Months	1 YEAR IF UNDER 24 HRS. Dovs Hours Min
Famale White WIDOWED TO DIVORCED	April 6, 1887 73 75	
10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUduring most of working life, even if retired)		ZEN OF WHAT COUNTRY?
Housewife		J.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
WILLIAM T. GRIER	Harriet Harkins	
[Yes, no, or unknown]	NFORMANT Address	
NO SI	pringfield Hospital Records, Syke	
18 CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c) ]		'INTERVAL BETWEEN
PART 1. DEATH WAS CAUSED BY. Confluent brond	hopneumonia	24 hours.
DUE TO		
	inoma to the liver	Months
gove rise to immediate DUE TO		
lying couse lost ) (c) Carcinoma of the		Months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT CHES ASSOC. With senile brain disease, 200 ACCIDENT WAS UNDERLYING TO DEATH OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		PERFORMED?
U CBS ASSOC. WITCH SETTITE DEATH CISCASS.	ED (Enter noture of injury in Port I of Port I of item 18)	Name of Street
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
5	LACE OF INJURY (Home, form, 20f (City or town) (octory, street, office bldg., etc.)	County) (State)
Hour a.m.  While Not while  p. m.  19 of work of work	ciory, street, office brugs, etc.)	
21 I certify that (I) (this hospital) attended the deceased from.	March 31, 1960 to August 4, 196	0. that (1) (we) last
saw the deceased alive on August 4, 1960, and that		
22g SGNATURE		22b, DATE
Constru del Campo	MD PHYS. DIRECTOR PHYS TO AT	igust 4, 1960
22c Thy SICIAN'S NAME (Type)	22d ADDRESS	122 163
Agustin del Campo, M.D.	Springfield State Hosp., Syke	esville, Ma.
230 BUR AL, CREMATION, 236, DATE THEREOF 230 NAME OF CEMETERY	OR CREMATORY 23d LOCAT ON (City town, or county)	(Stote)
15 mmal 8-6-60 Ginwood	Ceriter, Washington 7	DC
24 FUNERAL D RECTOR'S S GNATURE ADDRESS	250 REC'D BY REGISTRAR 256 REGISTRAR'S SI	
Deal Funeral Home 4812 Ga Ave	NEW DC DATE AUG 9 '60 Circles &	Thema

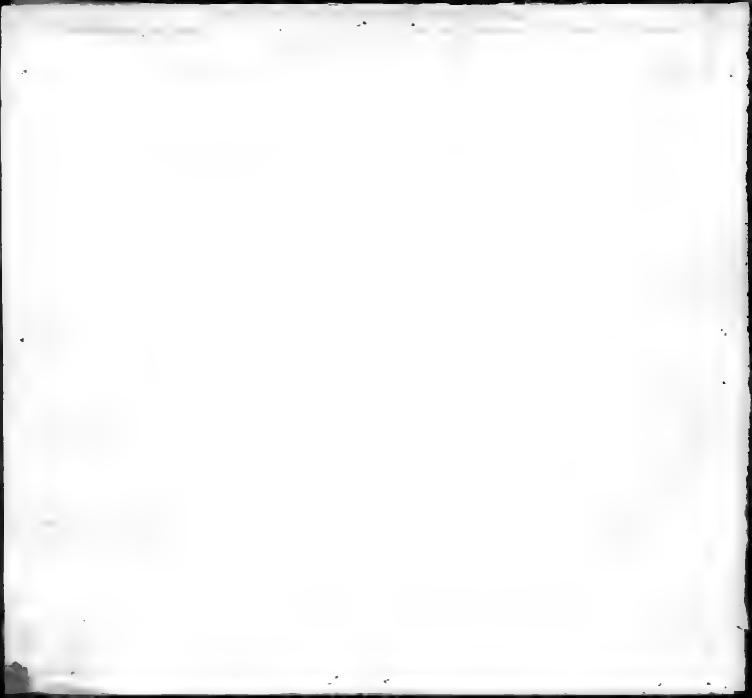
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after a death. Page 4 may be retained by the hospital or attending physician.

To function and completely filled in by the function of the functio

## MARYLAND STATE DEPARTMENT OF HEALTH 8 9 9 PHYLISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CEPTIFICATE OF DEPARTMENT OF HEALTH

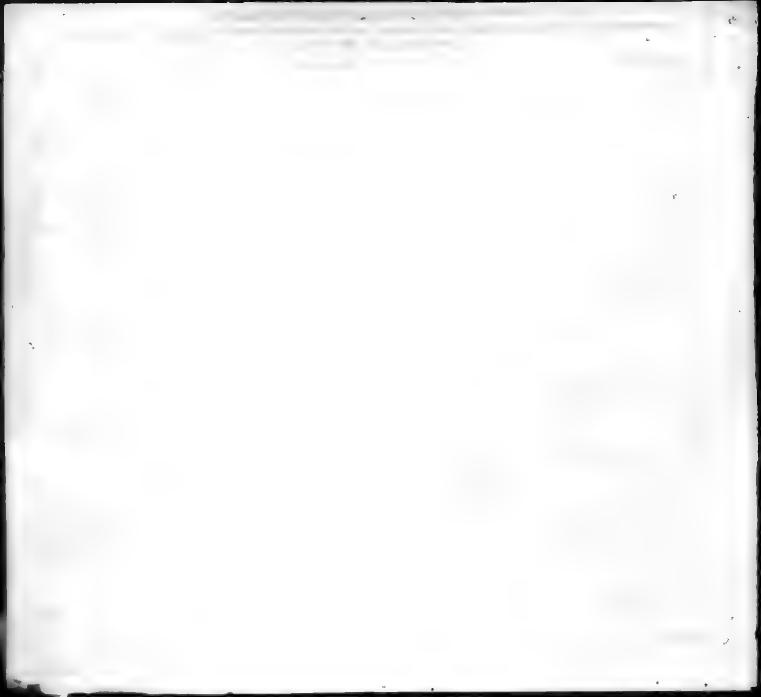
08971

PLACE OF DEATH o. COUNTY (	Carroll		MARYL		O STATE ME	ence (wheely lan	ere deceased	lived. If institution b COUNTY		roll	odmission)
b C TY OR TOWN (If outside corporate limits, write RURAL and give necrest town)  Rural Keymar  Lifetime					c CITY OR TOWN (If outside corporate I mits, write RURAL and give nearest town) RuralKeymar						
d NAME OF HOSI OR INSTITUTION			address)		d. STREET A		Channa	+ Pood		1	IS RESIDENCE ON A FARM? (ES M NO [
							Sharre				13 00 140 L
3. NAME OF DECEASED (Type or print)	Laur		Middle Virgin	nia	losi Hah		4 DATE OF DEATH	August		Doy 11	1960
s sex Male	White	7. MARR	IED NEVER MARRIE		July 4		1	AGE (In years lost birthday) 83 yrs	Manths		UNDER 24 HR
	TON (Give kind of work i		0448	$\rightarrow$					12 CIT	IZEN OF W	HAT COUNTRY
Houses	irking life, even if retired		Own Home		Max	yland				.S.A.	
13 FATHER 5 NAME		_		ļ	14 MOTHER'S						
) .	Samuel Angel	1				Mary	Brown				
75 WAS DECEASED ET	ER IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17 INFO	RMANT			Add	lress.		
No	EATH [Enter only one co	2	12-40-5984	Miss	Thelm	a Hahr	n , I	Keymar,	Md	R.I	
Canditions, if gave rise to couse (a), statin lying couse los	g the under-		Gene	ra	C DC	elic	ilit	7		7-	yrs
SAT	THER SIGNIFICANT CON	DITIONS C	ONTRIBLTING TO DEA	TH BUT NO	OT RELATED TO	THETERMIN	NAL DISEASE	COND TION GI	VEN IN PAS	` '	WAS ALTOPS PERFORMED? ES NO
THER, NOTI	VAS UNDERLYING [] IG [] CAUSE OF DEATH Y MEDICAL EXAMINER)	20b DESC	CRIBE HOW INJURY OC	CURRED	(Enter nature of	injury in P	ort Lar Part	11 of item 18)			
20c TIME OF INJUDICAL HOUR a, m	10	While	UURY OCCURRED Not while of work		E OF INJURY (I			or town)	(	County)	(Stat
	21 I certify that (I) (this haspital) attended the deceased from. How b. 1960 to Clug 10, 1960 that (I) (we) lost saw the deceased alive an Lile 10.1960, and that death occurred at 2 AM, from the causes and an the date stated above										
22a. SIGNATURE	J. N. 699 MD ATTENDING DIRECTOR STAFF AUG. 12.19										
22c PHYS C AN'S NAME (Type)	T, H.	LIE	56	MD	22d ADDRE	Elu	LQ-	uk	2re	6 CX	m
23a BURIAL, CREMAT REMOVAL (Specif Burial	ON 236 DATE THERECO		23c NAME OF CEME					ON (City, lown,		L, Ma	(Stote) cyland
24 FUNETAL/DIRECTO	THE THE	laney	ADDRESS town, Maryl	land			BY REGISTR		ISTRAR'S SI		



08972

	0000				
1 PLACE OF DEATH 0. COUNTY	Carroll	MARYLAND	2 USUAL RESIDENCE (W	here deceased lived finst tution: Reside D.C. b. COUNTY Pri	nce before odmission)
b. CITY OR TOWN RURAL and give r		c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside carporate limits, write RURAL and	give nearest town)
d. NAME OF HOSPI	TAL (If not in haspitar, give stree	of address}	d. STREET ADDRESS	ingston Road	IS RESIDENCE     ON A FARM?     YES    NO
NAME OF DECEASED	First	M ddie	Lost	4 DATE Month	Day Year
(Type or print) SEX	Lucy	Ford	Johnson	DEATH August	24, 19 60
Female		RRIED NEVER MARRIED DIVORCED	5-29-1888	9 AGE (In years list UNDE last birthday) 72 yrs.	Days Haurs Min.
Oa. USUAL OCCUPATE during most of war Unemploy	ON (Give kind at work done 19) rking life, even if retired)	KIND OF BUSINESS OR INDU		7.7	U. S. A.
3. FATHER'S NAME			14. MOTHER'S MAIDEN	NAME	
	ph Ford			ROWA	
5. WAS DECEASED EV	ER IN U. S. ARMED FORCES? 11; (If yes, give war ar dates of service)		nformant iamie Miller-	Address 8720 Livingston	Rd. Wash.,I
Candit ons, it a gave rise to cause (a), stating lying cause lost.	mmediate DUCTO	Jardiovascular oderately adva		rosis	
		CONTRIBUTING TO DEATH BU		Part Los Part II of Jem 18.	RT 1(a) 19 WAS AUTOPS PERFORMED? YES NO
	AS UNDERLY NG (1) 206 DE G (1) CAUSE OF DEATH Y MEDICAL EXAMINER)	Jenny How Hook I Occord	to. (tilla libiole of ilijosy ili	tan for four it of flate lary	
20c TIME OF INJU Haur a.m. p.m.	Whil		LACE OF INJURY (Home, form octory, street, affice bldg., etc	n, 20f. (City ar town)	(County) (Stafi
saw the decea	at (1) (this haspital) atterised alive an Augo	ided the deceased from 24, 1960, and that	August 22,19	50 to August 24, 16	O_, that (1) (we) la
	Edgars M. Macı	lans, Supt.		STAFF PHYS.	226 DATE S GNI
72c. PHYSICIAN'S NAME (Type)	Edgars M. Ma	enlany	22d. ADDRESS Henryt	on, Maryland	
REMOVAL SPECTO	18-28-60	236 NAME OF CEMETERY OF	1	23d. LOCATION (City, town, or county)	L MARYLA
Job . T.	~ D	ROIS IN The CA II	5 00	D BY REGISTRAN 256 REGISTRAR'S S	



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9()() MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118973

Reg. Dist. No.

V	PLACE OF DEATH  0. COUNTY		2. USUAL RESIDENCE (Where deci		on: Residence before admission)			
Λ	Carroll M/	ARYLAND	o. STATE Maryland		Balto.City /			
	b. CITY OR TOWN (if outside corporate timits, write RURAL ond give nearest fown)		c. CITY OR TOWN JIF outside o		URAL and give negrest town)			
	Sykesville 25yrs.1			·e -	v			
1	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street ad-	dress)	d STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
	Springfield State Hospital		630 Cokesbu	ry Ave.	YES NO Z			
1	3 NAME OF First Middle		tost 4 DATE	Month	Day Year			
	(Type or print) Charles		Killmon DEAT	a Augu	st 9, 19 60			
1	5 SEX 6. COLOR OR RACE 7- MARRIED NEVER MAR		DATE OF BIRTH	9 AGE (In years   I	FUNDER TYEAR IF UNDER 24 HRS.			
Î	Male White WIDOWED DIVORCE	ED 🔲	July 9, 1899	last birthday) OL yes,	Months Doys Hours Min.			
	10g, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS (	OR INDUST		country)	12. CITIZEN OF WHAT COUNTRY?			
ı	during most of working life, even if retired)	1	Maryland		U.S.A.			
-	13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
I	Charles W. Killmon		Elizabeth A.	White				
ì	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY N	10. 17. IN	FORMANT	Address				
1	(Yes, no, or enknown)  No		Springfield Hospi	Ltal Record	ls			
1	18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).	1		·	PHTERVAL BETWEEN			
	PART I. DEATH WAS CAUSED BY:	1000	redual inter.	etim)	ONSET AND DEATH			
	DUE TO COLOR OF THE PROPERTY O	7000	rdeal infar					
	(Conditions, if any, which)	Par	make a pator	cosolero	sis wears			
ı	gave rise to immediate cause		mary wice	-040 DEELE	aco acasoc			
ı	(a), stating the underlying				*			
1		ATH BUT N	OT RELATED TO THE TERMINAL DISE	ASE CONDITION GIVE	N IN PART 1(g) 19 WAS AUTOPSY			
	Schizophrenic reaction, paranoid type.							
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DE  Schizophrenic reaction, parance  200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH.  20b. DESCRIBE HOW INJURY OCCUPANT OF CONTRIBUTING CAUSE OF DEATH.	CURRED. IE	nter nature of injury in Part I ar Part	II of item 16.)				
1	PRIMARY   or CONTRIBUTING   CAUSE OF DEATH.	i		,				
ł	3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED	20e. PLA(	E OF INUURY (Home, form, 120f (C	ity or town)	(County) (State)			
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of work of work	facto	ry, street, office bldg., etc.)					
	21. 1 certify that I took charge of the remains descri		re held on Autonsy (T)	Inspection 🖼	Inquest 5 and find that			
	death resulted from: Natural causes . Accident [							
12	deom resolved from: National Eduses [], Accident		ide [], nomicide [],	Undetermined co				
ď	SIGNATURE SAMES J. There	1.	_M.D, CHIEF MEDICAL EXAMINER	_	DATE SIGNED			
1	SIGNATURE SECONDES . F TONY		_M.D. ASSISTANT MEDICAL EXAMI					
1	Examiner's Sames T. Marsh, M.D.		DEPUTY MEDICAL EXAMINER		8/10/60			
	1000-1000	ASTERN OR		hand				
	220 BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEN		The Site of	CATION ICITY, TOWN OF	Press Of A Sull			
	23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	7 1	240, REC'D BY REGE	STRAR 245 DEGIST	RAR'S SIGNATURE			
	Alight House Challens	for a	Med Bur 23	60	Can & Kraul			
J	Minister And I have	-//	DATE AUG 25					

VS A15ME(5) 5M 9/55

or removal.



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### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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()	3-	9	1	4
11	13	1.9	- 4	£.II
1 1	V	107	-	7

2. USUAL RESIDENCE (Where deceased used If institution Residence before admission) 1. PLACE OF DEATH a. COUNTY a. STATE 6 COUNTY MARYLAND Maryland Baltimore Carroll b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) 2 1100.16 Day Baltimore City 30 . . serville d NAME OF HOSPITAL (If not in haspital, give street address) 3008 Weddring Ave. IS RESIDENCE ON A FARM? OR INSTITUTION YES NO Springfield State Hospital NAME OF Furst M.ddle 4 DATE Month Last Doy Year DECEASED OF [Type or print] William DEATH 26 19 60 Edward ïdttle IF UNDER 1 YEAR IF UNDER 24 HRS 5 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9 AGE (In years last birthdoy) Manths Days Hours WIDOWED 4 DIVORCED 70 White Male 100 USUAL OCCEPATION (Give kind of work done) 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of warking life, even if retired) U.S.A. U.S.A. Racetrack guard TO FATHER'S NAME lizabeth 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address Springfield State Hospital Record yes CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) ]
PART I DEATH WAS CAUSED BY. Congestive Heart INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Days DUE TO Bilateral Pneumonia Days Conditions, if oily, which gove rise to immediate **DUE TO** cause (a), stating the underlying cause last. PART II, OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(01) 19 WAS AUTOPSY PERFORMED? C.B.S. associated with Senile Brain Disease YES 📆 NO 🗀 200 ACC.DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part I of item 18) DICAL 20c TIME OF INJURY Month. 20e. PLACE OF NJURY (Home, farm, 20f., City or town) Doy, Year 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) a. m. While Not while at wark 🔲 of wark p. m. 19 60 that (1) (we) last 21 I certify that (1) (this hospital) attended the deceased from ond that death occurred a45 P M, from the couses and on the date stated above. sow the deceased alive on 226 DATE 22a SIGNATURE 26/1960 SIGNED ATTENDING MED STAFF M.D PHYS DIRECTOR 22c PHYS C AN S 22d ADDRESS NAME (Type 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county) 23a BUR AL, CREMATION (State) REMOVAL (Specify) Baltimore National burial 256. REGISTRAR'S SIGNATURE 25g, REC'D BY REGISTRAR DATEUG 3 0 '60 Circling S. Krous



#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** 9003 Rea. Dist. No PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o COUNT Filed **5 COUNTY** MARYLAND KLO erol b. CJTY OR TOWN (If outside corporate limits, write c. C.TY OR TOWIN (If outside carporate limits, write RORAL and give nearest c. LENGTH OF STAY IN 16 RURAL and give negrest town) plnods CCCCCCIAL ECU d. NAME OF HØSPITAL (If not in hospita, give streek address) d STREET ADDRESS IS RESIDENCE ON A FARM? YES NO TO NAME OF W. ddla DATE Year Lost Month Day DECEASED OF DEATH (Type or print) 19 F UNDER 1 YEAR IF UNDER 24 HRS 5 SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years' last birthdov Months Doys ě WIDOWED K DIVORCED [T] campl 100. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) altre 13 FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO ę. 6 IB. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH <u>a</u> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) 5 **DUE TO** 6 Conditions, if any, which eq. gave rise to immediate DUE TO cause (a), stating the underlying couse lost. PART II OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS ALTOPSY PERFORMED? YES TO NO D 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of in vry in Port 1 or Port II of item 18.) 20c. TIME OF INJURY Month 20e PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year 20d INJURY OCCURRED (County) (State) factory, street, affice bldg , etc.) MED ra m Not while at work at work 21. I certify that I attended the deceased fram .\_\_\_\_. 19\_\_.that I last saw the deceased gc alive an and that death occurred at M, from the causes and an the date stated above. nay be retained by the FUNERAL DIRECTOR: ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL SIGNATURE prior 3 shaul PHYSICIAN'S NAME (Type) 22b DATE THEREOF 22ª BUR AL CREMATION. 22d LOCATION (City, fown, or county) 22c NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify the

**ADDRESS** 

246 REGISTRAR'S SIGNATURE

arthur & House

24a, REC'D BY REGISTRAR

DATE SEP

SA TO HOSPITA SA VE TO FUNERA TO FUNERA Poge 3 sh

PUNERAL DIRECTOR'S SIGNATURE

death

hat



#### MARYLAND STATE DEPARTMENT OF HEALTH

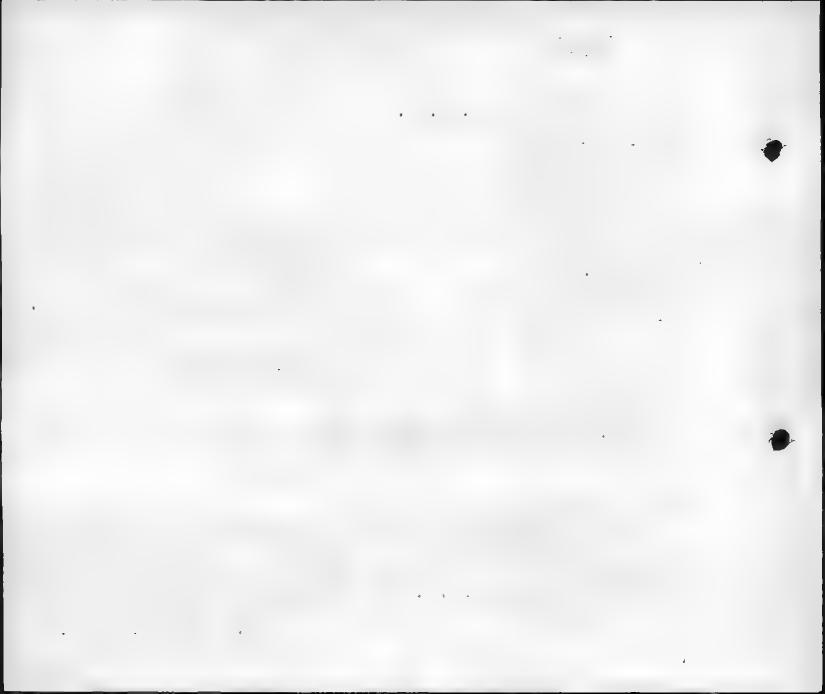
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08976

	4	CERTIFIC	SAIL OI DI				
a. COUNTY Car	roll	MARYLA		ence (Where decease	ed I ved If institut b COUNTY		fore admission)
b CITY OR TOWN (If or RURAL and give near Rural → Syke	utside carporate limits, write est tawn)	5 LENGTH OF STAY IN		own (If outside corp more City	oorgte imits, write l	RURAL and give r	rearest fawn)
d NAME OF HOSPITAL	(If not in hospital, give street State Hospital	oddress)	d STREET A	ooress ark Avenue	9 7	+	e is residenci on a farmi yes \begin{align*} NO \begin{align*}
NAME OF DECEASED (Type or print)	Mamile Mamile	Middle Josephi:	ne Mart	in deat			Doy Year 19 1960
female	white widows	IED NEVER MARRIED  DIVORCED [			9 AGE (In years lost birthday) 82 yrs	Manths Days	AR IF UNDER 24 H s Hours Mir
Oo USUAL OCCUPATION during most of working Decorator	(Give kind of work done 10b. g life, even if retired)	KIND OF BUSINESS OR I	,	CE (State or foreign	country)	12 CHIZEN	OF WHAT COUNT
3 FATHER'S NAME			14. MOTHER'S	MAIDEN NAME			
Alexander	T. Martin		Mar	y Wilson			
	N U S ARMED FORCES? 16.	SOCIAL SECURITY NO.	Springfiel			<sub>s</sub> Sykesv	ville, Md
CBS assoc.	redicte but to  grader but to  R SIGNIFICANT CONDITIONS G  With disturbs  UNDERVING [1] 206 DESC		H BUT NOT RELATED TO	THETERMINAL DISEA	SE CONDITION G	with	Years  19. WAS AUTOF PERFORMED YES NO.
20c TIME OF INJURY Have a m p m.	Month, Day Year 20d. II 19 While at war	Not while	le PLACE OF INJURY (I factory, street, affice			(Caunt	
saw the deceased	(4) (this haspital) attended alive an 8/19/		am 5/18/ nat death accurred	19 55 AM to at 8:35 A, from	8/19/ n the causes a		
220 SIGNATURE / ATTENDING MED STAFF TO 8/19/60							
22c PHYSICIAN'S NAME (Type)	Konstantin Web	er, M. D.	22d. ADDRE	sville, Ma	aryland		
BURIAL, CREMATION REMOVAL (Specify) Burial	8/22/60	23c NAME OF CEMETE Trinity	ery or crematory  Comotory	23d LOC <b>St</b>	Marv s C	ar caunty)	(State)
24 FUNERAL DIRECTOR'S	1	ADDRESS		250. REC'D BY REGI		ISTRAR'S SIGNAT	
W. CLARKE MAS	PTINGLEY LEON	GAM MUNDERED	VT.AND	DATE AUG 2	3 '60	Cultura &	Kine

Poge 4 ord 2 should be filed with TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haves after death may be retained by the hospital or attended yscalar.

TO FUNERAL DIRECTOR: After this cert ficats was been signed by the otherding physician and campletery filled the fine funeral page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be 6 the State Board of thea th prior to burial, cremation, an removal, and in any event, within 72 hours after death VR A15 (4) 15M 9/59



DIVISION OF	STATISTICAL	RESEARCH	AND	RECOR	D\$ —	BALT
5	CEI	RTIFICA	ATE	OF	DE/	ATH

	9005	CERTIFICA	ATE OF DEATH		(18977
	PLACE OF DEATH			iere deceased lived. If institution	Residence before admission)
	Carroll	MARYLAND	Maryla	and b county	Carroll
- 1	C. C.TY OR TOWN (If outside corporate limits, write	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF or	outside corporate limits, write RU	RAL and give nearest town)
I	RURAL and give nearest (awn) RuralEldersburg	ll yrs.	Rural H	Eldersburg	
-	NAME OF HOSPITAL (If not in haspital, give street OF INSTITUTION	address)	d STREET ADDRESS		e IS RES DENCE ON A FARM?
1	Liberty Rd., P.O. Syk	esville	Liberty Rd.	P.O. Sykes	Para Ver Day Office
- 1	NAME OF DECEASED Type or print)  ROBERT  First  GE	Middle ORGE	MILLER	4. DATE Month OF DEATH August	Day Year 4. 19 60
5 5	- 110 000	RIED NEVER MARRIED	B. DATE OF BIRTH	9. AGE ( n years last birthday)	FUNDER I YEAR IF UNDER 24 HRS
	Male White WIDOW	ED 👸 DIVORCED 🔲	January 12,	,1877 83 75	Months Days Haurs Min
10a	LSLAL OCCUPATION (Give kind of work done 10b during most of working life, even if retired)	KIND OF TOUR IND	LISTRY 11. BIRTHPLACE (State of	or foreign country)	12. CITIZEN OF WHAT COUNTRY?
2	Salesman Vi	sible Equip	t. Englan	ıd	England
13	FATHER'S NAME		14 MOTHER'S MAIDEN N	IAME	
/	Harry Miller		Mary P.		
	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. The control of unknown (If yes, give wer or doles of service)	SOCIAL SECURITY NO 17.	INFORMANT	Addre	"54 E. Patrick
_		77-09-9519	Mr. Clarence	ce C. Carty,	Frederick, Md
	18. CAUSE OF DEATH [Enter only one cause per li	ne for (a), (b) and (c).	, ,	126	ONSET AND DEATH
	PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (g)	Water the	enjekones 1	left howy	types 000
	DUE TO -	7 1	-1	10 /5	I my
	Conditions, if any, which ) (b)	Correderon	2 generaliza	&, Cunchu	10 70
	gave rise to immediate DUETO		d) . [		of Alexa hor
	tying cause last (c) f-12	emann,	meura -		777
CATION	Part II OTHER SIGNIFICANT CONDITIONS (	CONTRIBUTING TO DEATH BU	OT NOT RELATED TO THE TERMI	NAL DISEASE CONDITION GIVE	N IN PART 1(d) 19 WAS AUTOPSY PERFORMED? YES NO M
CERTIFI	20a. ACCIDENT WAS UNDERLYING ACCONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CRIBE HOW INJURY OCCUR	RED. (Enter nature of injury in P	<sup>p</sup> art I or Part II of item 18.)	•
EDICAL	Hour a.m. While	Not while f	PLACE OF INJURY (Home, form, actory, street, office bldg , etc		(County) (State)
×	p. m. 19 at wor	rk at work	0100	1 1/12	/
	21 I certify that (I) (this haspital) attend	led the deceased fram	21 July 19!	to to 4 Huy	, 19, that (I) (we) last
	saw the deceased alive on 4 / fug	19 مين , and that	death accurred at	M, from the causes/one	I an the date stated above.
	220 SIGNATURE	Vall.	ATTENDING ME	ED STAFF	22b DATE SIGNED

law requires that the death certificate be executed within 24 hours ofter death. Page 4 been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remaine carbon papers. Pages the State Board of Health prior to burial, cremation, or remaind and in any event, within 22 haurs after death TO HOSPITAL OR ATTENDING PHYSICIAN.

may be retained by the haspital or attend

TO FUNERAL DIRECTOR: After this certifical VR A15 (4) 1SM 9/59

director, 新

funerol

24 FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,

Aug.

22c. PHYSICIAN'S NAME (Type) Howard

Winfield,

Aug. 6,1960 Mt.

Hall

Maryland

23c NAME OF CEMETERY OF CREMATORY
Mt. Olivet Cemetery

M. D.

250 REC'D BY REG STRAR DAMIG B

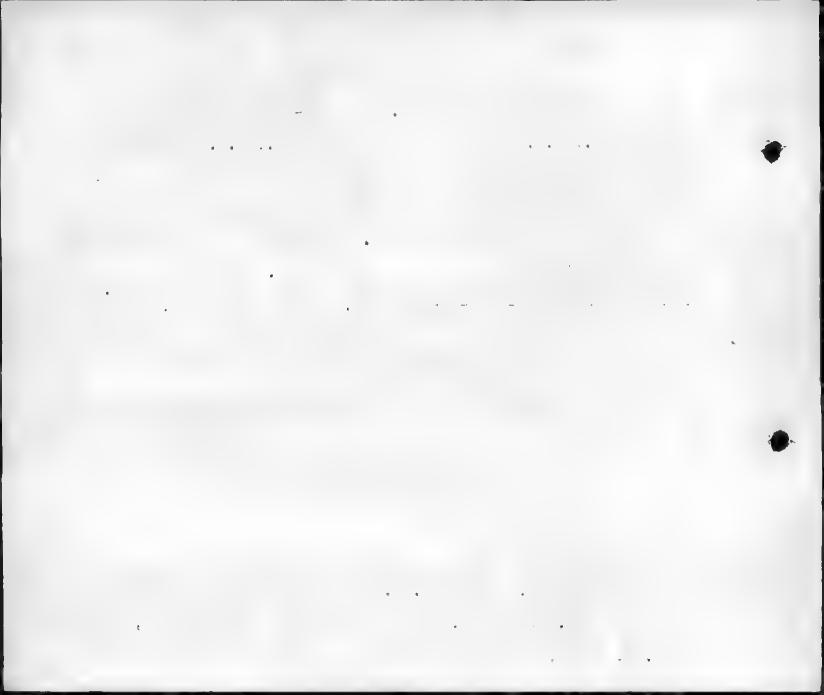
ATTENDING PHYS

22d ADDRESS

25b REGISTRAR'S SIGNATURE Circling S. Thomas

Maryland

23d LOCATION (City fown, or county)
Frederick





8983 **CERTIFICATE OF DEATH** TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 by the funeral director. PLACE OF DEATH bs been signed by the attending physicion and completely filter obtronsit permit. Then place remove carbon papers. Pages hours ofter death. may be retained by the haspital or ottendy—physician.

TO FUNERAL DIRECTOR: After this certification is been signed by the apage 3 should be detached for use as the buriol-transit permit. Then the registrar priar to buriol, cremotian, or removal, and in any event MEDICAL CERTIFICATION

08979 Reg. Dist. No.

b CITY OR TOWN (If autside corporate limits, write RURAL and give in RURAL and give negretal lown)  WESTMINSTER  d. NAME OF HOSPITAL (If not in haspitat, give street address)  d. STREET ADDRESS  d. STREET ADDRESS	nearest tawn)
d. NAME OF HOSPITAL (If not in hospital, a ve street address)	
d. NAME OF HOSPITAL (If not in haspital, give street address)  d. STREET ADDRESS	
OR INSTITUTION -	e. IS RESIDENCE ON A FARM?
23 PARKAUE. " 23 PARKAVE	YES NO DE
DECEASED	Day Year
(Type or print) / Y ARIS VIRGINIA MICONES DEATH Clinq	6 1960
1 4 f	AR IF UNDER 24 HRS
WIDOWED DIVORCED 400.3 843 64 YO	
during most of working life, even if retired)	OF WHAT COUNTRY
SCHOOL FACHEN I WALL SCHOOL - 101011 W	S.A.
JOHN MOONEY  NORA AMBROSE	
WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 ANFORMANT Address	
or no or unknown) Ill yes, give wor or derise of service) 208-26-875/1/25 EDKIN K. M. ADE 1. 337	19 1 STE1
	TERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: CA BECTUM - PERITONEAL METASTASIS	NSET AND DEATH
DUE TO	
Conditions, if any, which ) (b)	
gove rise to immediate couse (a), stating the under.	
lying cause lost (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO NO
200 ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	THE HOLEK
206. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH OF CONTRIBUTING  CAUSE OF CONT	
20c TIME OF INJURY Month, Doy, Year 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (County)	y) (Slote)
Haur o. m.  White Not white   Coctory, street, effice bldg., etc.)  p. m. 19 of work   of work	
21. I certify that I attended the deceased from $8-19$ , 1959, to $8-6$ , 1960, that I last	saw the deceased
alive on 5 4. M, fram the causes and an the d	l <mark>ate state</mark> d abave
ADDRESS (Street, city or town, stole)	DATE SIGNED
SIGNATURE AULUS / March M.O. / O.S.E. M.A.I.N. ST	<u>ي- د- ٥</u>
PHYSICIAN'S TAMES T. MARSH. WESTMINSTER	mx
O BURIAL, CREMATION, 226. DATE THEREOF, 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (C.ty, town, or county)	(State)
FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240, REC'D BY REGISTRAR 246 REGISTRAR'S SIGNAT	TURE
J. S. M. M. 16 & Still rate. T. J. DATE ANS 9 '60 auch & the	aut/A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

VS A15 (4) 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

:al nervous system

8:25 PF 28

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Sykesvi

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS --- BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATL!

08981

the funeral director, should be fixed with 2 should be fined 1111

campletely filled pours after may be retained by the haspital ar aftending systation.

TO FUNERAL DIRECTOR: After this certificate as been signed by the attending physician and page 3 should be #stochsoft for use the burial-transit permit. Then please remaye carbon fithe State Board of Health priar to burial, cremain an ar remayal, and in any event, within 72 he

W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 VR A15 (4) 15M 9/59

PLACE OF DEATH o. COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Reside o. STATE Maryland B. COUNTY Bal	to. County						
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town)  Sykesville  8 months 21 d	c. CITY OR TOWN (if outside corporate imits, write RURAL and Bys Baltimore	give negrest town)						
d NAME OF HOSPITAL ("F not a hospital, give street address) OR JNSTITUTION Spring field State Hospital	d STREET ADDRESS 2914 North Wind Road	IS RESIDENCE ON A FARM? YES NO S						
3 NAME OF DECEASED (Type or print) harles Frederick	Neubert 4. DATE Month Of DEATH	27 Year 60						
5. SEX  6 COLOR OR RACE 7 MARRIED NEVER MARRIED WIDOWED 15 DIVORCED	B DATE OF BIRTH 9-7-1878  9. AGE (In years If UNDE loss hirthday) 7. Wonths	R 1 YEAR IF UNDER 24 HRS Doys Hours Min						
10a USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDU during most of working life, even if retired)  Engineer  Payer 30x 60		TIZEN OF WHAT COUNTRY?						
(Yes the or enterior) . If yes a se was se state of service)	14. MOTHER'S MAIDEN NAME  LAROINE MEINER  Address							
NO 212-1C-3026 S  18 CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]  PART L DEATH WAS CAUSED BY	Springfield Hospital Records	INTERVAL BETWEEN ONSET AND DEATH Months						
Canditions, if ony, which agree rise to immediate (b)								
lying cause last. (c)								
PART: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1,0) 19 WAS PERFORM CBS assoc. With cerebral arteriosclerosis, with psychotic reaction YES TO								
OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ED (Enter nature of injury in Part I or Part I of Item 18.)							
20c T ME OF IN, URY Month, Doy, Year 20d INJURY OCCURRED Hour o. m. 19 at work at work	20c T ME OF IN.URY Month, Doy, Year 20d INJURY OCCURRED Hour o. m. 19 of work of at work of at work of the foctory, street, office bldg., etc.)  20e. PLACE OF INJURY (Home, farm, 20f. {City or town} (Caunty) (State)							
21 I certify that (I) (this haspital) attended the deceased from saw the deceased at ve an8=271960 , and that a	11-6-59 19 ta 8-27- 19 death accurred at 2:45%, From the causes and an the							
I for the section of	ATTENDING MED STAFF A DIRECTOR PHYS A PHYS Springfield Hospital, Sykes	226 DATE 9/27/60 sville, Md.						
230 BURIAL CREMATION. 236 DATE THEREOF 23c PIGME OF CEMETERY C SEMONAT (Spec fy) 8/3/40 PARKWOOD	OR CREMATORY 23d 10CATION (City, togn, or county)	) (State)						
24 FUNERA. DIRECTOR'S SIGNATURE ADDRESS 8807 HART	FARRY OF DATEAUG 3 1 '60 Chilles &							



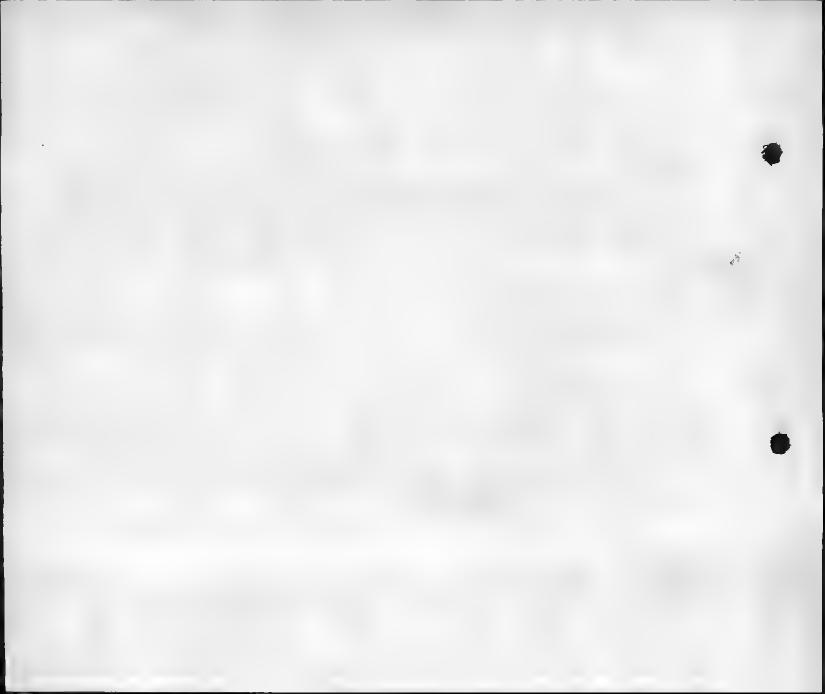
TO DEPUTY MEDICAL EXAMINER: This certificate shauld be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pendil in Item 18. Give Pages 1, 2, and 3 ta the funeral director. Page 4 should be farwarded to the Chief Medical Examin. Diffice along with farm PM3. Page 5 may be setained for your final to farwarded to the Chief Medical Examin. Diffice along with farm PM3. Page 5 may be setained for your final to burial, cremation. or removal.

VS. A15ME(5) 5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9()()() MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1/8982 Reg. Dist. No.

	1. PLACE OF DEATH O. COUNTY  THRROLL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)  o. STATE Maryland b. COUNTY Frederick						
	b. CITY OR TOWN  III outside corporate limits, write RURAL ond give nearest form)   C. LENGTH OF STAY IN 16   C. AAY S	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  R.F.D.1 Knoxville						
an wh	d. NAMINOPHOSPITAL OR INSTITUTION (If not in hospital, give street address)  SPRING FIELD STATE 1405PITAL	d STREET ADDRESS Potersville Road  on a FARM? YES   NO						
	3. NAME OF DECEASED (Type or print) CCRINE SHANK OF	Last 4. DATE OF Month Day Year OF DEATH 8 1960						
	S. SEX  6 COLOR OR RACE  7. MARRIED   NEVER MARRIED   8.  FINAL   WIDOWED   DIVORCED	DATE OF BIRTH  9. AGE (In years of burnday)  15 Tyre.  15 UNDER 1YEAR 1F UNDER 24 HRS  Months Days Hours Min.						
	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTR' during most of working life, even if retired)  HOME	Y 11. BIRTHPLACE (Storm or foreign country)  MARYLAND  12 CITIZEN OF WHAT COUNTRY?  U. S. A.						
1	CHARILES E SHANK	CLARIT BELL MUMERT						
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INT [Yes, no, or unknown] (If yes, give war or dotes of service)	HOSPITAL RECORDS						
	Conditions, if any, which gove rise to immediate cause (a), stating the underlying couse tast.  PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO ABETES AFILLIAN COURTED, (ED.)  20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED, (ED.)	TREATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES NO DISEASE OF THE TERMINA OF THE						
	20c. TIME OF INJURY Month, Day, Year While Not while factor of work 21. I certify that I taak charge of the remains described above							
	death resulted from: Natural causes \( \bar{\text{N}} \), Accident \( \bar{\text{N}} \), Suicide \( \bar{\text{N}} \), Homicide \( \bar{\text{N}} \), Undetermined cause \( \bar{\text{L}} \).  ACTUAL SIGNATURE \( \bar{\text{SIGNATURE}} \)  EXAMINER'S \( \bar{\text{NAME}} \)  ASSISTANT MEDICAL EXAMINER \( \bar{\text{L}} \)  DEPUTY MEDICAL EXAMINER \( \bar{\text{L}} \)  DEPUTY MEDICAL EXAMINER \( \bar{\text{L}} \)							
	220. BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Spec by)  23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  ADDRESS	REMATORY 22d LOCATION (City, town, or county) (Sudie)  24d. REC'D BY REGISTRAR (24b. REGISTRAR'S SIGNATURE  24d. REC'D BY REGISTRAR (24b. REGISTRAR'S SIGNATURE)						



#### **CERTIFICATE OF DEATH** Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution) Residence before admission) . COUNTY **b. COUNTY** MARYLAND after deoth. b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) shavid d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION within 24 hours NAME OF First Middle DATE Last DECEASED OF DEATH GUS (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED A NEVER MARRIED 8. DATE OF BIRTH 9 AGE (In years lost birthday) Months WIDOWED [ DIVORCED [7] 100 USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE 12. CITIZEN OF WHAT COUNTRY? bad during most of working life, oven it retired) HOUSEWIFE 13. FATHER'S NAME offer SNADER certificote 17. INFORMANT IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. Address HUSBAND ending 1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (cf.) ä PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) DENOCARCINOMA **DUE TO** Š ony Conditions, if ony, which gove rise to immediate **DUE TO** casse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY emayo. 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, fEnter nature of injury in Port I or Port II of item 18.) O 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Doy, Year 20d. INJURY OCCURRED factory, street, office bldg., etc 1 0. m. While Not while of work of work D. m 1960 that I last saw the deceased 21. I certify that I attended the deceased from should be detached alive on and that death occurred at / M, from the causes and on the date stated above. DIRECTOR: ADDRESS (Street, city or town, stote) ACTUAL SIGNATURE May be ... O HOSPITAL PHYSICIAN'S NAME (Type) 220 BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) REMOVAL (Specify) 0 23. FUNERAL DIRECTOR'S SIGNATURE 2 ADDRESS REC'D BY REGISTRAR 24b, REGISTRAR'S SIGNATURE 240 VS A15 (4) arthur S. Krous DATE 1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08383

6. IS RESIDENCE

Hours

INTERVAL BETWEEN ONSET AND DEATH

16 MOS

PERFORMED?

YES NO 2

(Stote)

(Stote)

(County)

Day

ON A FARM?

YES NO Z

Year



#### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08984

	9011	CERTIFICA	IE OF DEATH							
	PLACE OF DEATH COUNTY Carroll	MARYLAND	2 USUAL RESIDENCE (Where dece o. STATE Maryland	b COUNTY Carr						
	b. CITY OR TOWN (If outside corporate limits, wi RURAL and give nearest town)		c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give near  5mos.3days  New Windsor							
, ,,	d. NAME OF HOSPITAL (If not in hospital, give store in National Control of the co	treet address)	d STREET ADDRESS		e. IS RESIDENCE ON A FARM?					
or or	Springfield State Hosp	ital	Route #1		YES NO					
1	3. NAME OF DECEASED (Type or print) Mary V	irginia Hatfiel	d Porter 4. DA	4	21, Yeor 60					
	73 9 175 2 4 .	MARRIED NEVER MARRIED DOWED DOWED DIVORCED	B. DATE OF BIRTH October 4, 1884		TYEAR IF UNDER 24 HRS. Days Hours Min.					
	100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		STRY 11 BIRTHPLACE (State or foreign	n country) 12 CT:	ZEN OF WHAT COUNTRY?					
	Hoasewife	-	Maryland	U.i	S.A.					
1	3 FATHER'S NAME		14, MOTHER'S MAIDEN NAME							
	Unknown		Amelia Porter							
-	15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wer or dates of service)	16. SOCIAL SECURITY NO. 17. II	NFORMANT	Address						
	No -	_	Springfield Hosp	ital Records	·					
	1B. CAUSE OF DEATH [Enter only one couse ;		INTERVAL BETWEEN ONSET AND DEATH							
	PART L DEATH WAS CAUSED BY.  Bronchopneumonia									
	DUE TO									
	Conditions, if only, which ) (b)									
	gove rise to immediate DUE TO									
	lying cause lost.									
	C.B.S. assoc. with seni	ONS CONTRIBUTING TO DEATH BUT LLE Drain disease	NOT RELATED TO THE TERMINAL DE S	EASE CONDITION GIVEN NIPART	1(0) 19 WAS AUTOPSY PERFORMED? YES NO.					
	OR CONTRIBUTING CAUSE OF DEATH	DESCRIBE HOW INJURY OCCURRE	D (Enter noture of injury in Port I or	Port II of item 18 )						
			ACE OF INJURY (Hame form, 201, actory, street, affice bldg. etc.)	(City or town) (C	ounty) (Stote)					
	E p m 19	work ot work								
	21 1 certify that (I) (this hasp'ta ) at	tended the deceased from.	March 18, 1960	August 21, 196	O, that (I) (we) last					
	saw the deceased alive an Augus									
4	220 SIGNATURE	10/1			22b, DATE SIGNED					
1	Clouden del	Campo	M D PHYS MED DIRECTOR	THYS TO	8/22/60					
	NAME (Type) Agustin del	Campo, M/D.	Springfield	Hospital, Sykes	ville, Md.					
	230 BUR AL, CREMATION, 236 DATE THEREOF	23c NAME OF CEMETERY C		OCATION (City town or county)	(State)					
3	Burral Aug. 24,19	60 Taylorsvil	le Cemetery	Carroll Co.,	Maryland					
3	24 FUNERAL DIRECTOR'S S GNATURE	ADDRESS	250 REC D BY RE AUG 2 4	GISTRAR 256 REG STRAR'S SIG	MATURE					
3	C. M. Waltz, Winf:	ield, Marylan	Id DATE	60 C June 4. 1	U) and					

within 24 hours ofter death. Page 4 Then please remove carbon papers. Pages 1 and 2 may be revained by the haspital or attend prysicion.

TO FUNERAL DIRECTOR: After this certificate as been signed by the ottending physicion and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. low requires that the death contribute be executed TO HOSPITAL OR ATTENDING PHYSICIAN:

the funeral director, should be filed with

VR A15 (4) ISM 9/59



08985

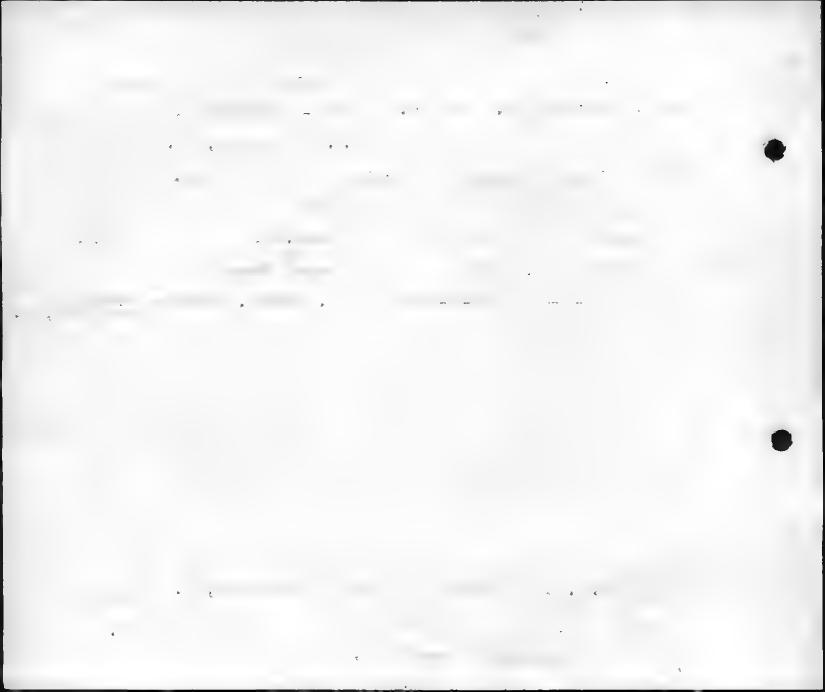
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1 PLACE OF DEATH 0. COUNTY				USUAL RESIDENCE (W	There decease	d lived. If institution b COUNTY	an: Reside	nce befare	e odmiss	pon)
Carroll		MARYL	AND	Maryland Carroll						
b CITY OR TOWN (f autside carporate limi RURAL and give nearest tawn)	ls, write	E LENGTH OF STAY II	N 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Rural Middleburg		5 months	3	Tanevto	wn					
d. NAME OF HOSPITAL (If not in haspital, g OR INSTITUTION			1	d. STREET ADDRESS				e		FARM?
Brookfield Manor Nu	rsing	Home		63_York	_Stree	t			1E2 []	NO DE
3. NAME OF Fir DECEASED (Type or print) Isai		Middle Lewis	10	eifsnider	4. DATE OF DEATH	Augu		Day		Year 1960
S SEX 6 COLOR OR RACE		D NEVER MARRIED	1	ATE OF BIRTH	-	9. AGE (In years		RIYEAR		ER 24 HRS
Male White	WIDOWED	_	- LJ	arch 3, 18	72	last birthday) 88 yrs	Months	Doys	Haurs	Min
10a USJAL OCCUPATION (Give kind of work	dane 10b K	IND OF BUSINESS OR				country)	12 CI	TIZEN OF	WHATC	OUNTRY
during most of working life, even if retired Farmer	)	Own Farm		Maryla	_			U.S.	A.	
13 FATHER'S NAME			3.4	MOTHER'S MAIDEN	NAME					
Isaiah Willi	am Re	ifsnider		R	lebecca	Lippy				
15 WAS DECEASED EVER IN U.S. ARMED FOR	CES? 16. S	OCIAL SECURITY NO	17, INFOR	MANT		3 2 3 Add	East	Hano	****	9+
(Yes na, or unknown) (If yes, give war ar dates of s		VINE	Mr.	Raymond Re	ifsnid	ler, Hanor	ver,	Penn	sylu	ania
18. CAUSE OF DEATH [Enter only one co	per ine	for (a), (b), and (c).]		,	44	4-			RVAL BE	
PART I. DEATH WAS CAUSED BY	In	mic Mur	care	letis and	hurre	andial []	100000	a set in	PW .	154
DUE TO							1			-
Conditions, if any which )	V		10/1	4 /1-1	11/10	and si			51	200
gave rise to immediate	) (		100	- Clercy	ver.	7			-	
cause (a), stating the under.	)		*							
lying cause last.										A IVANOV
PART II OTHER SIGNIFICANT COM	DITIONS CO	ONTRIBLT NG TO DEAT	TH BUT NO	RELATED TO THE TER	WHAL DISEAN	SE COND HONG	VEN IN PA	KI, I, a), 19	PERFO	JEWEDL
3 Hermanzia U	Deminalized artirioslinus armicephist postales 450 NO 1									
200. ACCIDENT WAS UNDERFING OF OR CONTRIBUTING OF CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	206. DESC!	RIBE HOW NURY OC	CURRED (E	nter nature of injury in	n Part I or Pa	rt (I of 'tem 1B)				
20c. TIME OF INJURY Manth, Day, Ye Haur a. m. p. m. 19	or 20d IN.	JURY OCCURRED	20a. PLACE	OF INJURY (Hame, fai	rm, 20f (Cit	y or town)		(County)		(State
Hour a.m.	While at wark	Not while	ractary	, street, affice bldg., e	(c.)					
			. 17	holus.		2/12/1	20.10			
21   certify that (I) (this hasoite	attende		- /	F. L. f T. f	9, ta_					(we) last
saw the deceased alive an 2.11	7/4	20_19 _ and 1	that deat	accurred at	M, fram	the causes at	nd an th	e date		
220 S GNATURE S.S.									5 GNED 5 GNED	
22c PHYSICIAN'S		71		22d. ADDRESS	-			ď		7 /
NAME (Type) K. S. A	JOV	augh		16	mo	estre	in		m	1
23a BURIAL, CREMATION, 23b DATE THEREC	OF.	23c NAME OF CEME	TERY OR CE	EMATORY	23d LOC/	TION City, town	ar county)		(Stat	ie)
REMOVAL (Specify) Burial Aug. 16.	1960	Reformed	Comet	'A770		town. Car			ryla	hne
24 FUNERAL DIRECTOR'S SIGNATURE	1/100	ADDRESS	Velic I		C,D BA KEGIS	TRAR 255, REG	STRAR'S S	IGNATUR	RE T	1111
hab - 46 611	- MA	The Mark Mark	0222		UG 17'	60 Ci	Mus &	. There	j.A.	
U.U.Fuss & Son	Ia	neytown, Ma	arArgi	IU DAIL H	100					

VR A1S (4) ISM 9/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

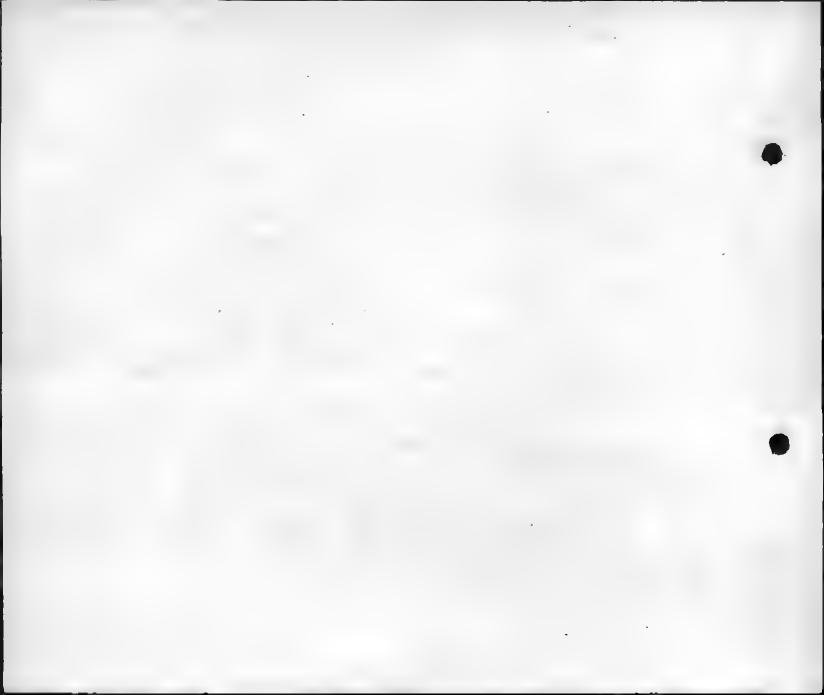


VR A15 (4) 1SM 9759

## 9013

### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1 PLACE OF DEATH 0. COUNTY Carroll		MARYL	- 11	USUAL RESIDENCE (WM o. STATE Marylan		aved If institute b. COUNTY	on Residence		missian)
b. CITY OR TOWN (If outs de cor RURAL and give nearest tawn)	porote limils, wr	c. LENGTH OF STAY IN	N 16	c. CITY OR TOWN (IF o	**	rate limits, write R			lown)
Rural Taney	town	60 years		Rural	Taneyt	own			
d NAME OF HOSPITAL (If nat in OR INSTITUTION	haspital, give sti	reet address)		d STREET ADDRESS				Ó	RESIDENCE N A FARM?
3 NAME OF	First	Middle		Last	4. DATE	Mon	th	Day	Year
OECEASED (Type or print)	Samuel	David		Snider	OF DEATH		ust	21	19 60
5 SEX 6 COLOR	OR RACE 7. A	AARRIED 🗌 NEVER MARRIED	D S B D	ATE OF BIRTH	į	9, AGE (In years lost birthday)	$\overline{}$	YEAR IF J	NDER 24 HRS
Male Whit	1	OWED DIVORCED	U 0	CHILLIACET A THE	874	86 yrs			
10a USUAL OCCUPATION (Give kinduring most of working life, ever	d of work done	106. KIND OF BUSINESS OR	INDUSTRY	11. BIRTHPLACE (State	ar fareign ca	runity)	12 CITIZ	EN OF WH	AT COUNTRY?
Laborer	•	Day Labor		Marylan	nd			U.S.A	1.
13. FATHER'S NAME			1	4. MOTHER'S MAIDEN N	IAME				
William	A. Snid	er			Alic	e Bower			
15 WAS DECEASED EVER IN U. S. A. (Yns., no., or unknown) If was, give wor	RMED FORCES? or dates of service)	16 SOCIAL SECURITY NO	17 INFO	RMANT		Add	ress		
No	Of Oliver of Military		Mrs.	Carl Baumga	ardner	, Little	stown,	Penr	18.
18 CAUSE OF DEATH (Enter of	inly one cause p	er line for (a), (b), and (c).		ON					L BETWEEN
PART 1. DEATH WAS CA		scenti (17	Mid	in Mr	my to	74		3	min
420.1	DUE TO	4 4 4				4 . 6			
Canditions, fany, which )	. (1	ATGAL PACICE	na Ti	( Cally D.	DUAC	11/01/81	18010	//	VILLE
gave rise to immediate	(b) C	O WO UN US	<u>u</u> - 000	Contro	0 .0 .0	00-01 00-	and the		
couse (a), stating the <u>under-</u> ( Tyrng couse last.									U
	(c)	NS CONTRIBUTING TO DEAT	THE SLOT NO	T DELATED TO THE TERM	NEAL PRICE ACT	COMPITION CA	IEN NI DADT	1/=1/19 W	AS ALITOPSY
O FART II OTHER STOREFTS	ANT CONDITIO	NS CONTRIBUTING TO DEAT	IN BUT NO	I KELATED TO (HETEKAN)	MWC DISCASE	COMPITION GA	EN NEFARI	PE	RFORMED?
Part II OTHER SIGNIFIC 200 ACCIDENT WAS UNDERLY! OR CONTRIBUTING CAUSE ( (IF EITHER, NOTIFY MEDICAL EX	NG [] 20b DF DEATH (AMINER)	DESCRIBE HOW INJURY OC	CURRED (E	inter noture of injury in I	Part Lar Port	(I of item 1B)			
20c. TIME OF NSURY Manth,	w W	hile Nat while wark at wark		OF INJURY (Hame form, street, affice bldg., etc.		ar tawn)	{Ce	อยกty)	(State)
₹ pm	· u	work   or work	7	1/30	<del></del>	0/11	1	73	
21 I certify that (I) (this	haspital at	ended the deceased f	fram	19	3_(, ta	0/2/	, 19 <i>1</i> 20		I) (wa) last
saw the deceased glive	an	19.6. V and t	that deat	th accurred at/100	M, fram	the causes ar	d on the	date sta	ited abave.
220 SIGNATURE	O his	11.		ATTENDING 🝆 MI		STAFF		8/11	225 DATE SIGNED
22c PHYSICIAN'S	~ 110	TULY	M.D	PHYS DI	RECTOR L	PHYS 📙		2/ X X	160
NAME (Type)	POT	TER M. I	0.	LILIT	TLE	STOW	NL	'PA	,
230. BURIAL, CREMATION, 23b, DA	TE THEREOF	23c. NAME OF CEMET	TERY OR C	REMATORY	23d LOCAT	ION (City, Iawn,	ar county)	1	(State)
Burial Aug.		O Harney L	uther	an Cemetery	Harne	y, Carro	11 . ME		nd
Mercury (	-tuss)			DATE AL		20			
C O Fuste & S	an	Tenertown Md		DATE AL	la Co (	20	inner &	France	



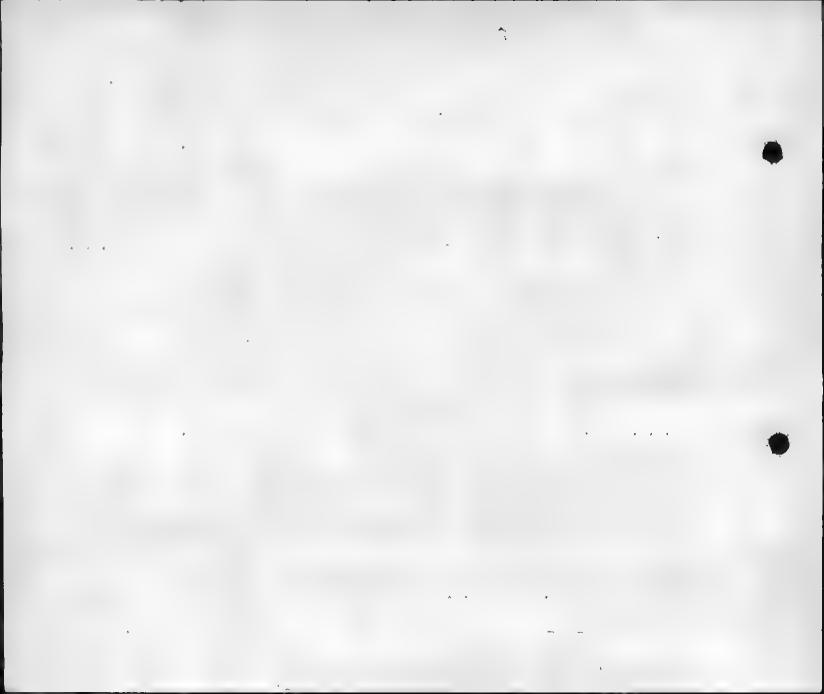
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9()14 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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	-			يباز ب يا ب	<u> </u>		TI-OU EV			Key. Ott	1. 140.			
)		LACE OF DEATH						E (Where dece		d. If Institut on Residence before admission)				
		Car	roll		MARYL	AND	o. STATE Maryland b. COUNTY Balto. City							
	b	b. CITY OR TOWN (If autude corporate limits, write RURAL on STAY IN 16 ond give nearest town)			c. CITY OR TOWN	4 (If outside co	orporate limits, write	RURAL and	ive negrest town)					
, mine		Sykesville 1 mo. 12 days			Balti	more 1	4	SV	4					
3			·		spital, give street address)		d. STREET ADDRES				e. IS RESIDENCE ON A FARALZ			
		Springfie	ld State He	ospita	al	l	5010	Crosswo	ord Ave.		YES NO T			
	3. [	NAME OF DECEASED	Fir		Middle		Loui	4. DATE	Mon	th	Day Year			
		Type or print)			Hopkins		picer	DEATI	nugui		12, 1960			
	5. S	EX	6. COLOR OR RACE	7. MARRI	IED NEVER MARRIED	8.	DATE OF BIRTH	1884	9. AGE (In years lost barthday)	Months D	YEAR IF UNDER 24 HRS			
1		Female	White	WIDOWE		3 10 6	anuary 15,	1882	76 74 yrs.					
	10c.	. USUAL OCCUPATION of working	N (Give kind of work) I life, even if retired)	done 10b.	KIND OF BUSINESS OR II	1DUSTR	Y 11. BIRTHPLACE (S	tote or foreign	country	12. CITIZI	EN OF WHAT COUNTRY			
		Housewife	9		-		Maryla				U.S.A.			
!	13.	3. FATHER'S NAME				14 MOTHER'S MAIDE	EN NAME							
		William Hopkins					Mary -							
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 18 You, or unknown)   18 you, give wer or dotes of service)				17, INI	FORMANT		Addres	h.				
									<u>tal Reco</u>	rds				
			H [Enter only one cou	se per line	for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
		PARE IL DEAL	IMMEDIATE CAUSE (6)	Arte	<u>erioscleroti</u>	c c	ardiovascu	lar dis	19386		Years			
		Ho.	DUE TO											
		Conditions, if any, which agree to immediate cause												
		(0), stating the u												
		couse last. (c)												
	CATION	PART H. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY C.B.S. assoc. with senile brain disease with psychotic reaction.												
	CERTIF	20g EXTERNAL CAU PRIMARY G or CON CAUSE OF DEATH.		D. DESCRIB	SE NOW INJUST OCCURS	ED. (Eñ	ier naivre at injury in	Fort   or Fort	Il of ilem 18 )					
	MEDICAL	20c. TIME OF INJUR	Y Month, Day, Yes			- PLACI	E OF INJURY (Home, y, street, office bldg.,	form, 20f. (C	ity or town)	(Coun	ly) (State)			
	MED	Hour o.m.	19	While of wi	le Not while	Ideioi	y, missi, orrice coug.,	eicij i						
		21. I certify th	at I taok charge	af the	remains described	abav	e, held on Auto	opsy 🔲,	Inspection 🗷	, Inquiry	, and find the			
		death resulted	from: Natural	causes [	Z, Accident	Suic	ide 🔲, Hamic	ide 🔲, I	<b>Undetermined</b>	cause .				
			0		1 %.									
		ACTUAL SIGNATURE	Laur	(0)	J. Mary	4	M.D. CHIEF MEDICA	L EXAMINER [			DATE SIGNED			
	Н	EXAMINER'S	1/2-71	V	3/ D		ASSISTANT ME	DICAL EXAMIN	NER 🔲		0/20//0			
		NAME (Type)	James T. 1				DEPUTY MEDIC		_		8/12/60			
	220	BURIAL, CREMATION PREMOVAL (Specify)	N, 22b. DATE THEREC		22c. NAME OF CEMETER	_			ATION (City, lown,		(Stote)			
8		burial	8-15-60	1	Woodlawr	2 (	emetery		ltimore	*				
	23.	FUNERAL DIRECTOR	S SIGNATURE	205	ADDRESS	1		REC'D BY REGI		ISTRAR'S SIGN				
Leonard J. Ruck 5305 Harford Rd DATE ANG 15 60 DATE														

VS. A15ME(5) 5M 9/55



		MARYLAND STATE	DEPARTM	ENT OF HEALTH	-BALTIMORE, 1	18 119090
E B		9016 c	ERTIFICA	TE OF DEATH		(18989 Reg. Dist. No.
IVI)	1. P	ACE OF DEATH COUNTY	MARYLAND	2. USUAL RESIDENCE (Whe	re deceased lived. If institution. COUNTY	on: Residence before admission)
	t	CITY OR TOWN (If outside corporate limits, write C LENGTH RLRAL and give nearest fown)	OF STAY IN 16	c. CITY OR TOWN (IF o	fiside corporate limits, write R	URAL and give nearest town)
	(0	NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION	1545	d STREET ADDRESS	DI COL	e. IS RESIDENCE ON A FARM?
i	E	THE OF First CEASED	M.ddle	Lost	4. DATE Mon	
	5 S		ER MARRIED	THOMA S  B. DATE OF BIRTH	9. AGE (In years lost birthdoy)	IF UNDER 1 YEAR IF UNDER 24 HRS.
<b>'</b>	100	JSLAL OCCUPATION (Give kind of work done 10b, KIND OF BU!	DIVORCED D	TRY 11. BIRTHPLACE (Stole o	7 8 yrs.	Months Days Hours Min.
	13.	Juring most of working life, even if retired)	· - · -	CANAL  14. MOTHER'S MAIDEN NA	160.72d	U.S.Q.
	16 1	AS DECEASED EVER IN U. S. ARMED PORCES? 16. SOCIAL SECL	9/7 9/7 NO 112 II	Peles	era?	
		o, or unknown) (If yes, give wor or dates of service)	3.5 72	is Putt 7	n. Fletcher	Same addre
		8. CAUSE OF DEATH (Enter only one couse per line for (o), (b), PART 1. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (o) CONSE	ond (c).]	HEART P	AKURA	INTERVAL SETWEEN ONSET AND DEATH
		DUE TO	TENSI	VE ARTELIOS	CIFIATIC.	
		gove tise to immediate cotts (o), stating the under lying cause lost.			SLAR X SEA	ase 5-4RS
	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION				VEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
		DO. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW I	NJURY OCCURRED	). (Enter noture of injury in Po	ort I or Port II of item 18.)	YES NO 🔀
	ر ب	Oc. TIME OF INJURY Month, Day, Year 20d INJURY OCCU Hour o. m. While Not whi	ile foc	ACE OF INJURY (Home, form, lory, street, office bldg., etc.)	20f. (City or tawn)	(County) (State)
		1. I certify that I attended the deceased from.	JUL	4. 1957, to_2	4UG. 30, 1860	2, that I last saw the deceased
j		0 11: 1 /	nd that death		M, from the causes of DDRESS (Street, city or town,	and on the date stated above state) DATE SIGNED
		CTUAL WILLIAM L. SEAL HYSICIAN'S	rail,	M.D. 19 12	OGE RD	1406.30,196
-	720	FAME (Type)	OF CEMETERY O	WESTI		MD
	1	NEMOVAL (Specify) Junt 3 (0)	+1132	Meinel B	22d. LOCATION (City, town, o	N lordon RDHI
	23.	E Tricy in A / hi y therein	Tin 121	DATEP 1	BY REGISTRACE 246. REGIS	STRAR'S SIGNATURE
٤		/ /				



EOD OTATE	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESION STREET, BALTIMORE I, MARTLAND
FUR STATE	8984 MEDICAL EXAMINER'S CERTIFICATE OF DEATH (1899)
HADII DEPI.	1 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased I vad, if institutions Residence before admission)
SE F M	e. COUNTY  Carroll  MARYLAND  a. SIATE Maryland  b. COUNTY Carroll
いた。世紀と	b CITY OR TOWN (if outside corporate limits, LENGTH OF STAY IN 1b CITY OR TOWN (If outside corpora a limits, write RURAL and give nearest lown)
8 8 8 8 A	Westminster  Westminster  Westminster
dir.	d NAME OF HOSPITAL OR INSTITUTION (I not in hosp ta , e va streat address)  d STREET ADDRESS  e IS RESIDENCE
B B B	19 Roda, Rad   Street YES   NO PA
at tate	3 NAME OF Fi st Middle Last 4. DATE Month Day Year
T ta ta a	OF CEASED (Type or print) WILLIAM R. VEIGA DEATH August 15 1960
4224	5 SEX 6 COLOR OR RACE, 7 MADDIED NEVED MADDIED 18. DATE OF BIRTH 9. AGE III YEAR IF UNDER 24 HRS
de la company de	Male White WOOWED DIVORCED A. 1957 Last birthday Months, Deys Hours Mr.
12, a 15, a	10a USUAL OCCUPATION (G ve kind of work 10b, KIND OF BUSINESS OR INDUSTRY) 11. BIRTHPLACE (State or fore gin country) 12. CITIZEN OF WHAT COUNTRY
s 1,	dona during most of working fits, evan if refrad),
전 8일 등 82 돌	N3 PATHER'S NAME  14. MOTHER'S MAIDEN NAME
7 5 5 5 7 T	January 11 1/44 Con Jone Hillone:
	AS AS DECEASED EVER IN U.S ARMED FORCEST To. SOCIAL SECURITY NO 17 INFORMANT Address 54 Chase ST.  [You no, or unknown) (Hystorya water datasofsas (ca)]
188 A 188 A	(Yash no, or unkown) (Ifyasgiva war or datas of saylea) - Mark (m. 11, 1/1/10 ) In the treasent in mark
witer Ten Ten Per III	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
marit	PART I DEATH WAS CAUSED BY ACUte, interstitial pneumonitis, bilateral
be e aldi	492 X DUE TO
o d History	§ Conditions, if any, which \ (b)
S S S S S S S S S S S S S S S S S S S	gava rise to immadiate cause
din	(a), stating the underlying Social (c)
Life Cam Lise Cam	
2 2 2 2 2 V	PERFORMED?    YES   NO
and dies	PART II. OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 a 19. WAS AUTOPSY PERFORMED?  20a. EATERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part 1 or Part
ER. Me sho ial,	E PRIMARY OF CONTRIBUTING C CAUSE OF DEATH.
DINI Para Series Pura Series	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or lown) (State)
AK 60 of c	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (C.ly or lown) (County) (State)  Hour a.m. While Not While p.m. 19 at work at work
Si de de Constant	21. I certify that I took charge of the remains described above, held an Autopsy 🗷, Inspection [], Inquiry [], and in my opinion
Harry F	death resulted from Natural causes . Accident . Suicide . Homicide . Undetermined manner
DIC arden BEC	CHIEF MEDICAL EXAMINER
ME DE T	SIGNATURE DATE SIGNED DATE SIGNED
Sinat feet	DEPLTY MEDICAL EXAM NER
	NAME (Type) Russell S. Fisher, M.D. Address (Streat, cly, town, or county)
DEPU sase ex should FUNE its des	22a BURIAL, CREMATION, 22b DATE THEREOF 22c. NAME OF CEMETERY OF CREMATORY 22d TOCATION (City, town, or country) (Stala,
0 2 4 0 9	REMOVALAUG 18, 1960 Calvary Cemeters Chicopic Muss
YS, A15ME	23. FUNERAL DIRECTOR ADDRESS ADDRESS REC'D BY REG STRAN 246, REGISTRAN'S SIGNATURE
5M 7/59	X'2' Myln fr. Wathmister md. DATE AUG 18'60 Chilling S. Krous

Them 17 Film 275 11-23-MARYLAND STATE DEPARTMENT OF HEALTH



## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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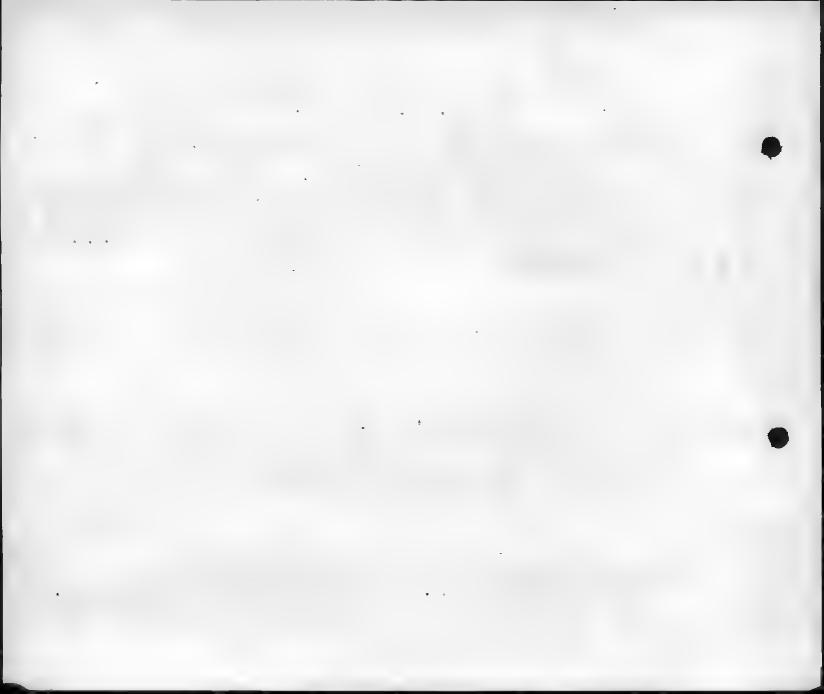
triling d. Mars

PLACE OF DEATH	2	USUAL RESIDENCE (Where d		Residence before admission)				
o. COUNTY Carroll	MARTIANII	o. STATE Maryland	P. CONILA	Balto City				
b CITY OR TOWN (if outside corporate limits, write	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside	e corporate limits, write RURA	L and give nearest town)				
RURAL and give nearest town) Sykesville	Lyrs. 3mos. 22day	ys Baltimor	e 24					
d. NAME OF HOSPITAL (If not in hospital, give street	address)	d STREET ADDRESS	,	B IS RES DENCE ON A FARM?				
Springfield State Hos	spital	505 S. E		YES NO 1				
NAME OF DECEASED (Type or print) June Est	ther Wisniewski	Wallace	DATE Month OF DEATH Augus	Doy Yeor st 23. 19 60				
SEX 6 COLOR OR RACE 7 MAR	RIED NEVER MARRIED 1 8	DATE OF BIRTH		INDER TYEAR IF JINDER 24 HE				
Female White widow	/ED DIVORCED T	June 25, 1899	61 yrs.	onths Days Hours Min				
DE USUAL OCCUPATION (Give kind af work dane 10b during most of working life, even if retired)	KIND OF BUSINESS OR INDUSTR	Y 11, BIRTHPLACE (Stole or fo	reign country)	12 CITIZEN OF WHAT COUNTR				
None House wife 2	17-20-2346	Michigan		U.S.A.				
, FATHER'S NAME		14 MOTHER'S MAIDEN NAME						
Albert Wisniewski		Ida - Sta	aniewski					
WAS DECEASED EVER IN U. S. ARMED FORCES? 16	SOCIAL SECURITY NO 17 INFO	RMANTO OAC DOA	VOL 1923 Address	Quentine Re				
Yas, no or unknown [If yes, give war or dates of service]	- S	m, R. Walle pringfield Hos		uenune je				
18. CAUSE OF DEATH [Enter only one cause per li		**		INTERVAL BETWEEN ONSET AND DEATH				
PART I DEATH WAS CAUSED BY Arteriosclerotic cardiovascular disease								
4-32 1 DUE TO								
Conditions, if any, which ) Pyelonephritis								
gove rise to immediate DJE TO	,							
ying couse lost (c)	Bronchopneumonia			Days				
Schizophrenic reaction			D SEASE CONDITION G VEN	IN PART I(a) 19 WAS AUTOPS PERFORMED? YES NO				
	SCRIBE HOW INJURY OCCURRED (	Fotor nature of innity in Port	or Part II of stem 18 )	1 .m []af				
OR CONTRIBUTING CAUSE OF DEATH		sino norono on injery miron						
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	INHERV OCCURRED 26e PLACE			(County) (Sta				
	Not while factor	E OF INJURY (Home, farm, 20, y, street, affice bldg., etc.)		(County) (Sto				
20c TIME OF NJURY Month, Day, Year 20d Hour o. m, 19 at wo	Not while factor	E OF INJURY (Home, farm, α γ, street, affice bldg., etc.)	Of (City or town)					
20c TIME OF NJURY Month, Day, Year 20d Hour o. m., p. m. 19 While at wo 21 1 certify that (1) (this haspital) attended	Not while factor at work ded the deceased from Maj	E OF INJURY (Home, farm, y, street, affice bldg., etc.)	of (City or fown)	19_60 that (1) (we) Id				
20c TIME OF NJURY Month, Day, Year 20d White at wo 21 1 certify that (1) (this haspital) attentions the deceased alive an August	Not while factor at work ded the deceased from Maj	E OF INJURY (Home, farm, y, street, affice bldg., etc.)	of (City or fown)	19_60 that (1) (we) la				
20c TIME OF .NJURY Month, Day, Year 20d Hour o. m., p. m. 19 While at wo 21 1 certify that (1) (this haspital) attended	Not while factor at work ded the deceased from Maj	20 F INJURY Home, farm, 20 y, street, affice bldg., etc.)  7 31 19 55	of (City or town)  , tAugust 23,  Varam the causes and c	19_60 that (1) (we) la				
20c TIME OF NJURY Month, Day, Year 20d Hour o.m., p.m. 19 While at wo 21 1 certify that (1) (this hospital) attends as the deceased alive an August 22a s GNATURE	Not while factor at work ded the deceased from Maj	TOF INJURY Home, farm, 20, street, affice bldg., etc.) 21, 1955  ath accurred at 1079	of (City or town)  , tAugust 23,  Varam the causes and c	19.60 that (1) (we) la				
20c TIME OF NJURY Month, Day, Year 20d Hour a.m., 19 While at wo 21 1 certify that (1) (this hospital) attends as the deceased alive an August 22a s GNATURE  CAGNISTIN ALL CA	ded the deceased framMaj  23 19 60, and that dec	COF INJURY Home, farm, 20, street, affice bldg., etc.)  The street affice bldg., etc.)	of (City or town)  , taugust 23,  Aram the causes and cook PHYS T	19.60 that (1) (we) loan the date stated above 225 DATE 8/214/6				
20c TIME OF NJURY Month, Day, Year 20d Hour o.m., 19 While at wo 21 I certify that (I) (this haspital) attends saw the deceased alive an August 22a S GNATURE	ded the deceased framMaj  23 19 60, and that dec	COF INJURY Home, farm, 20, street, affice bldg., etc.)  The street affice bldg., etc.)	of (City or town)  , tAugust 23,  Varam the causes and c	19.60 that (1) (we) loan the date stated above 225 DATE 8/214/6				
20c TIME OF NJURY Month, Day, Year 20d Hour a.m., p.m. 19 White at wo 21 I certify that (I) (this haspital) attention saw the deceased alive an August 22a s GNATURE 22c PHYSICIAN'S NAME (Type) Agustin delCar	ded the deceased framMaj  23 19 60, and that dec	e OF INJURY Home, farm, 20, street, affice bldg., etc.)  1955  1955  th accurred at 8:10P)  ATTENDING MED PHYS DRECT  22d ADDRESS  Springfield	of (City or town)  , taugust 23,  Aram the causes and cook PHYS T	19.60 that (1) (we) loon the date stated above 22b DATE 8/21,760 esville, Md.				
20c TIME OF NJURY Month, Day, Year 20d Hour a.m., p.m. 19 While at wo 21 I certify that (1) (this hospital) attention saw the deceased alive an August 22a s GNATURE 22c PHYSICIAN'S NAME (Type) Agustin delCar	ded the deceased framMaj 23,19,60, and that dec	e OF INJURY Home, farm, 20, street, affice bldg., etc.)  1955  1955  th accurred at 8:10P)  ATTENDING MED PHYS DRECT  22d ADDRESS  Springfield	of (City or town)  . tAugust 23,  Marain the causes and cook PHYS CK  Hospital, Syke	19.60 that (1) (we) loon the date stated above 225 DATE 8/214/6				
20c TIME OF NJURY Month, Day, Year 20d Hour a.m., p.m. 19 White at wo 21 I certify that (I) (this haspital) attention saw the deceased alive an August 22a s GNATURE 22c PHYSICIAN'S NAME (Type) Agustin delCar	ded the deceased framMaj 23,19,60, and that dec	e OF INJURY Home, farm, 20 20 21, 1955  If accurred at 19:10P, 22d ADDRESS  Springfield  REMATORY 23d	of (City or town)  . tAugust 23.  Mram the causes and cook OR D PHYS X  Hospital, Syke LOCATION (City town arca  Raxio, City	19.60 that (1) (we) loon the date stated above 22b DATE 8/214/6				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs ofter death. Page 4 may be retained by the haspital or attending vision.

O FUNEBAL DIRECTOR: After this certificate to been signed by the attending physician and completely filled the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban pagers. Pages 1 and 2 should be fied with the State Board of Health prior to burial, cremation, ar removal, and in ony event, within 72 haurs after death. the funeral director. may be retained by the haspital ar attending TO FUNETAL DIRECTOR: After this certificate

VR A15 (4) 15M 9/59



VR A1S (4) 1SM 9/S9

MARYLAND	<b>STATE</b>	<b>DEPARTMENT</b>	OF	HEALTH

91) 1 8 DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

)		A. COUNTY  Carroll	MARYLAND	2 USUAL RESIDENCE (Who o. STATE Marvl	re deceased lived of institution of b. COUNTY (J.):	Residence before admission) ashington
/	Ŀ	CITY OR TOWN (If autside corporate limits, write	c. LENGTH OF STAY IN 16		itside corporate fimits, write RURA	
		Sykesville	28 days	Hagersto		*
		d NAME OF HOSPITAL (If not in hospital, give street	*	d STREET ADDRESS	*	e IS RES DENCE ON A FARM?
		Springfield State Hospit	tal	806 Mulbe	rry Ave.	YES NO I
		NAME OF DECEASED (Type or print)  Rudolp	Max	lest W <b>eiss</b>	4. DATE Month OF August	25, 19 60
	S. S	6 COLOR OR RACE 7 MARI Male White WIDOW	RIED NEVER MARRIED DIVORCED DIV	December 10,	face barebaras 11	UNDER 1 YEAR IF UNDER 24 HRS onths Days Hours Min
	1	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Silk mill employee	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stole Germany	or fare gn country)	12 CITIZEN OF WHAT COUNTRY?
	13.	FATHER'S NAME	. i	14. MOTHER'S MAIDEN N	AME	
		Unimer ROOLPIT V	UE IS\$	Agnes El		
				IFORMANT	Address	
		No -	51-05-0/c95	oringfield Hos	pital Records	
1		IB. CAUSE OF DEATH [Enter only one cause per li				INTERVAL BETWEEN
	)	PART I DEATH WAS CAUSED BY An	teriosclerotic	heart disease		Years
_/		Conditions, if ony, which (b) Gel	neralized arter	riosclerosis		Years
		cause (a), stating the under-				
	CERTIFICATION	C.B.S. associated with s	CONTRIBUTING TO DEATH BUT Enile brain di	NOT RELATED TO THE TERMIN	NAL DISEASE CONDITION GIVEN	N PART I(0) 19 WAS AUTOPSY PERFORMED? YES NO
		206 ACCIDENT WAS UNDERLYING TO CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRE	D (Enter nature of injury in P	ast for Port II of Item 18)	*
	MEDICAL	20c. TIME OF INJURY Month, Day, Yeor 20d. 1 Hour a. m. While p. m. 19 of war	Nat while fa	ACE OF INJURY (Hame, form, clory, street, office bldg , etc.		(County) (State)
		21 I certify that (I) (this haspital) attend	ded the deceased fram.s	July 27, 10	O to August 25,	, 19 <u>60</u> , that (I) (we) lost
Ì		sow the deceosed olive on August	19 <u>00</u> , and that a	leath occurred aLU:	MAMom the couses and a	on the date stoted obove 22b DATE
		Digustin de	1 Crupo		STAFF	8/25/60
F		PAGE (Type) Agustin delCa	mpo, M.D.	Springfie	d Hospital,Syke	sville,Md.
	230	Survey 8 7760	230 HAME OF CEMETER C	ww. Cem.	Hogesslor	cery Mad
,	24	FUNERAL DIRECTOR'S SIGNATURE	aguslout	71.	$=$ $\mathcal{U}_{-}$	AR'S SIGNATURE
6			7			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death. Page 4 may be retained by the haspital or ottending physicion

TO FUNERAL DIRECTOR: After this certificate has have been a shauld be defacted for use as the burning the State Board of Health prior to burning.

VR A15 (4) 15M 9/59

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

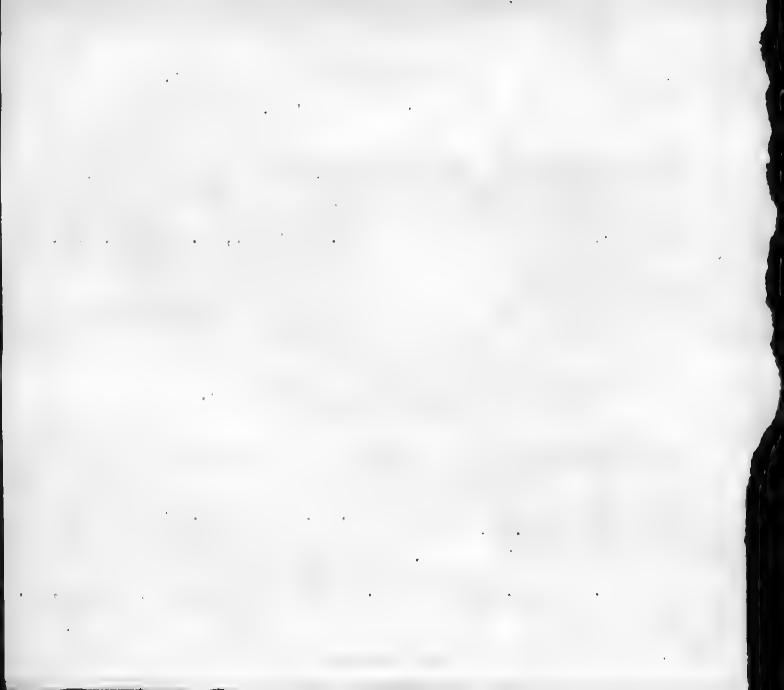
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and 2 should be fi ed

real signed by and then please remove corban papers. Pages I matian, or removal, and in any event, within 72 haurs after death

#### **CERTIFICATE OF DEATH**

		V 1/ 4. V			_		
)		PLACE OF DEATH D. COUNTY Carroll	MARYLAND	2 USUAL RESIDENCE (W o. STATE Maryland		residence COUNTY St. Mary	1
		b CITY OR TOWN (If outside corporate limits, write	c LENGTH OF STAY IN 16		outside corporate I mits		
		RURAL and give nearest town) Henryton	180 days	Colton's	Point.		
		d NAME OF HOSPITAL (If not in hospital, give street OR NSTITUTION	address)	d STREET ADDRESS	1	7 \ / .	e IS RESIDENCE ON A FARM?
		Henryton State Hospita				1-3	YES NO
		NAME OF DECEASED (Type or print)  Walter	Thomas	Young	4. DATE OF DEATH	Month August	20, Yeor 20, 1960
	5 5	6. COLOR OR RACE 7. MARR	HED NEVER MARRIED	8 DATE OF BIRTH	9 AGE (		YEAR IF UNDER 24 HR
		Male Negro WIDOWE		1-1-1874	86	ALE WOULD	days Hours Min
	10a	USUAL OCCUPATION (Give kind of work done 10b during most of working life, even if retired)	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stot	e or foreign country)	12 CITIZE	N OF WHAT COUNTRY
:		Uyster Shucker		St. Mary'	s Co., Md.	τ	I. S. A.
1	13,	FATHER S NAME		14. MOTHER'S MAIDEN	NAME		
	_	Thomas Young		Henriett	a Young		
	15 (Yes	WAS DECEASED EVER IN U. S. ARMED FORCES? 16 Inc. or unknown] [ (If yes, give wer or dates of service)	SOCIAL SECURITY NO. 17. P	NFORMANT		Address	
		No		Walter Thom	as Young -	- Patient	
		IB CAUSE OF DEATH [Enter only one couse per lin	ne for (a) (b) and (c)]				INTERVAL BETWEEN
			Cardiovascular	rinsufficie	ncy		ONSE! AND DEATH
		/ / X MENETELII					
		Conditions, if ony, which ) (b) A	rteriosclerot	tic heart di	sease		
		gave rise to immediate DUE TO					
		rying couse lost (c) I	Moderately adv				
	CERTIFICATION	PART H. OTHER SIGNIFICANT CONDITIONS C	ONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERA	MINAL DISEASE CONDIT	TION G VEN IN PART I	(o) 19 WAS AUTOPSY PERFORMED? YES NO
		20g ACCIDENT WAS UNDERLYING (CONTRIBUTING COURSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRE	D. (Enter nature of injury in	Port 1 or Part 11 of iter	n IB)	
	MEDICAL	Hour o.m. While		ACE OF INJURY (Home, for ctory, street, office bldg., et	m, 20f. (City or town)	(Co	unty) (State
		21   certify that (1) (this haspital) attend	led the deceased fram.	Feb. 22. 19	60 la Aug	20., 1960	, that (I) (we) las
		saw the deceased alive an Aug. 20	19 60, and that a	death accurred at 3.1	ON, fram the cau	uses and an the o	date stated above
		220 SIGNATURE Edyars M. Ma	enlary		AED. STAFF		22b. DATE SIGNEI
		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
		Dr. Edgars M. M	laculans, Supt	t. Henryton	State Hos	spital, He	nryton, Mo
	230	BUR AL, CREMATION, 236 DATE THEREOF	23 NAME OF CEMETERY O		23d LOCATION (City		(Stote)
		Burial 8/23/60	All Saints		Oakley,		Md.
	24.	FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	250. REC	D BY REGISTRAR 2	56. REGISTRAR'S SIGN	
	4.0	W. CLARKE MATTINGLEY I.E.	ONLY DID MONDE SEED	DATE A	uic 2 a 160	1 0.2	Museum



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Signal Signal	After this certifical	hed far use as the	
DISTRICT OF STATES	: After this certifical	ched for use as the	
DISTRICT OF STREET	R: After this certifical	ached far use as the	
DISTRICT OF STREET	R: After this certifical	tached far use as the	
DISTO D CHARLES	OR: After this certifical	etached far use as the	
The major of distance of	CIOR: After this certificate has been signed by the attending physician	detached far use as the burial-transit permit. Then please remave carb	

ARYLAND	STATE DEPARTMENT OF HEALTH—BALTIMORE,	18
3020	CERTIFICATE OF DEATH	D

Reg. Dist. No. 8394

1. PLACE OF DEATH o. COUNTY Car	roll County		MARYLAND	2. USUAL RESID	ence (Wh		ived. If instituti b. COUNTY	-	e before odm	ission}
b. CITY OR TOWN (II RURAL and give no	outside corporate limits,		LENGTH OF STAY IN 16				te limits, write R		jive nearest to	wn)
d. NAME OF HOSPIT. OR INSTITUTION	AL (If not in hospital, give			Old We	DRESS	gton Ro			ON	ESIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	First Thomas		Middle G <b>loyd</b>	Zendgraf		4. DATE OF DEATH	Mor Aug	13	Day	Year 19 60
5. SEX	No. De	MARRIEI	NEVER MARRIED	B. DATE OF BIRTH			AGE (In years last birthdoy) 53 yrs.	IF UNDER Months	1 YEAR IF UN Days Hour	
boiler-f:	ing life, even if retired)		ND OF BUSINESS OR IND	Mar	land		ntry}		S.A.	COUNTR
3. FATHER'S NAME	G. Zendgr	aft		14. MOTHER'S	-	wame wokingh				
	R IN U. S. ARMED FORCE	ica)		informant sister - D	B. J.	oseph H	i. Marti	ress M.		
Conditions, if or gave rise to in couse (a), storing t lying couse lost.	mmediate but to column the under- column to column the column term to column term term to column term term term term term term term term	TIONS CO	riginal and MIRIBUTING TO DEATH BU	T NOT RELATED TO	THE TERMI	alona INAL DISEASE (	CONDITION GIV	ven in par	PERI	S AUTOPS FORMED?
200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING 20 20 CAUSE OF DEATH MEDICAL EXAMINER)	0Ь. DESCRI	BE HOW INJURY OCCURE	ED. (Enter nature of	injury in	Port I or Port I	l of item 1B.)			
20c. TIME OF INJURY Hour o. m. p. m.	Y Month, Day, Year 19	While	URY OCCURRED 20e.	PLACE OF INJURY (Foctory, street, office	ame, farm bldg., etc	20f. (City o	r town)	(0	(ounty)	(Stat
21. I certify the alive on  ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	at 1 attended the a S/13/60	., 19	, and that deal	6/5 \$ h accurred at		M, fram th	et, city or town,	nd an the	date state	decease ed abov ATE SIGNI
220. BURIAL, CREMATIO REMOVAL (Specify)			22c. NAME OF CEMETERY	OR CREMATORY	Ann ann ann idea ann idea dad		ON (City, Iown,		(5)	lote)
Burial 23. EUMERAL DIRECTOR	8/16/60	, ,	Westminster ADDRESS	Cemetery	04- BEC"	Westa D BY REGISTRA	minster	Md.	ENIATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 68995 9021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Carroll MARYLAND Maryland Balto City buriol b. CITY OR TOWN III outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and give negres! town) 20vrs Limos . Lidays Baltimore Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Springfield State Hospital 1212 W. Pratt St. YES NO DE NAME OF 4. DATE Middle Month DECEASED (Type or print) Pearl Ziegler DEATH August 19 60 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8. DATE OF BIRTH 9. AGE Un veora IF UNDER TYEAR IF UNDER 24 HRS. Days July 23, 1899 WIDOWED | White DIVORCED [ Female. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Clerical work Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Andrew Ziegler Margaret Yakel 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Springfield Hospital Records. No 18. CAUSE OF DEATH | Enter only one cause per ling for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO A. S. C.V. disease Conditions, if ony, which; gove rise to immediate cause **DUE TO** (a), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY Schizophrenic reaction, paranoid PERFORMED? NO K 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) Patient fell to the floor on the ward. Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY 20f. (City or town) (County) (Stole) HOSDITAL While Not while Svkesville Carroll Md. 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection X. Inquiry M, and find that death resulted fram: Natural causes X Accident Suicide . Hamicide . Undetermined cause DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE-0 0 cute the cert farworded to D FUNERAL ASSISTANT MEDICAL EXAMINER 8/4/60 James T. Marsh. M.D. EXAMINER'S DEPUTY MEDICAL EXAMINER NAME (Type) 220. BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, fown, or county) (Stote) 0 LADDRESS 23. FUNERAL DIRECTOR'S SIGNATURE 24g, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE AUG 1 0 '60 Circlian S. Thomas

VS. A15ME(5) 5M 9/55

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